Primary care in the Irish Republic has undergone a substantial transformation over the last decade.

The need to restructure primary care and change the philosophy of health care was essential; primary care services were fragmented and did not maximize the collective potential of community-based health professionals. Delivering a philosophy of care that is person centred requires a service that is community based and available outside normal working hours. Previously, the emphasis was on treating ill health, rather than promoting better health and wellbeing (Department of Health and Children (DOHC), 2001). International health policy outlined in the Alma Ata Declaration as far back as 1978 (World Health Organization, 1978) directed a worldwide movement towards population-focused preventative health care at primary care level.

In Ireland, as throughout Europe, demographics reflect an ageing population. Life expectancy has risen by 18 months for Irish males and 15 months for females in the period 1995-2003 (Central Statistics Office, 2007). It is estimated that within the next 20 years one in four of the Irish population will be over 65 years (Health Service Executive (HSE), 2007). Statistically, 62% of this older population will have a chronic disease and it is predicted that 80% of this same group will be managed at a primary care level rather than requiring acute secondary care (HSE, 2008a).

Thus, the Irish health service required a proactive population-driven approach in order to meet the changing health needs of the Irish people. The Primary Care Strategy (DOHC, 2001) established a community-driven model designed to strengthen the capacity of services at primary care level, so that dependency on secondary care could be minimized. This strategy promotes lifestyle choice, an approach which empowers people to take responsibility for their health. It is envisaged that this can be achieved through accessibility to local multidisciplinary primary care teams. Core team members include general practitioners (GPs), practice nurses (PNs), public health nurses (PHNs), community registered general nurses (CRGNs), home help services, occupational therapist, physiotherapist, social worker and an administrator. A wider network of additional professionals will work with a number of primary care teams providing services not available within the core team (Box 1). It is anticipated that by 2012, 530 teams will be established nationwide (Drumm, 2009a). The number and

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**ABSTRACT**

Primary care health services in the Irish Republic have undergone fundamental transformation with the establishment of multidisciplinary primary care teams nationwide. Primary care teams provide a community-based health service delivered through a range of health professionals in an integrated way. As part of this initiative ten pilot teams were established in 2003. This research was undertaken in order to gain an understanding of nurses’ experiences of working in a piloted primary care team. The methodology used was a focus group approach. The findings from this study illustrated how community nurse’s roles and responsibilities have expanded within the team. The findings also highlighted the benefits and challenges of working as a team with various other community-based health-care disciplines.

**KEY WORDS**

Primary care + Primary care teams + Community nurses
range of health professionals involved in each team is based on local needs assessment and the population size (DOHC, 2001). Ideally, each team should have the capacity to meet the health and social needs of the population they serve (DOHC, 2004). In 2002, the DOHC identified ten primary care teams as pilot projects in various locations throughout the Irish Republic. These projects provide a practical demonstration of the primary care model in practice (DOHC, 2004). This study investigated the experiences of community nurses working in four pilot teams.

**Community nursing**

In the Irish Republic, state employed community nurses are collectively known as public health nurses (PHNs) (Brady et al, 2008), and are the largest and longest established nursing group in the community (Leahy Warren, 1998). PHNs are educated to deliver clinical, management and preventative care to individuals, families and communities within a defined geographical area (National Council for the Professional Development of Nursing and Midwifery (NCPDNM), 2005). The public health nursing service has expanded considerably in the last 20 years. Owing to a shortage of PHNs in the late 1980s, CR.GNs were introduced to support PHNs in providing general nursing care (Moore, 2006). Home help services and health-care assistants were introduced following the Health Act, 1970 (Department of Health, 1970). These home support services are now well developed and closely allied to the public health nursing service. While community mental health nurses, clinical nurse specialists and palliative care nurses provide community nursing services they work and report within their own administrative framework (Hanafin et al, 2002). PNs are attached to GP services and are privately employed by GPs. A subsidy of 70% is paid towards the PN’s salary by the HSE to GPs participating in the state funded General Medical Service scheme (Irish Nurses and Midwives Organisation, 2010). Responding to the increasing number of nursing disciplines in the community, the Commission on Nursing (1998) identified the need to develop a framework which would co-ordinate community nursing services (Government of Ireland, 1998). Following implementation of the Primary Care Strategy it became essential to present a future vision for community nursing practice. However, the Institute of Community Health Nursing (ICHN) acknowledged the failure to develop such a framework has resulted in a haphazard expansion of nursing services without any clear plan for strategic integration or professional development (ICHN, 2007).

The increasing number of nursing disciplines now working in the community has also impacted on the PHN’s role (Government of Ireland, 1998; NCPDNM, 2005). Furthermore, owing to increased patient throughput and demands on hospital resources, the level of clinical and general nursing care in the community has increased (HSE, 2006; ICHN, 2007). These changes to care arrangements in turn are impinging on time and resources that previously PHNs would have allocated specifically to health promotion (Begley et al, 2004; Philibin et al, 2010). Some of these developments present challenges to providing an equitable population-based nursing service (HSE, 2006). Additional barriers to achieving this objective include the lack of sufficient documentary evidence of the PHN’s workload and that PHN ratios are calculated on population size rather than on complexity of care (Begley et al, 2004; Hanafin and Cowley, 2005). There is also evidence of interdisciplinary tensions between community nursing disciplines (Scott et al, 2006; O’ Neill and Cowman, 2008). Research findings to date indicate that delivering an equitable and accessible community-

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**Table 1. Profile of participants**

<table>
<thead>
<tr>
<th>Nursing discipline</th>
<th>Focus Group 1</th>
<th>Focus Group 2</th>
<th>Focus Group 3</th>
<th>Focus Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health nurse</td>
<td>Three</td>
<td>Three</td>
<td>Three</td>
<td>Five</td>
</tr>
<tr>
<td>Community registered general nurse</td>
<td>One</td>
<td>One</td>
<td>One</td>
<td>One</td>
</tr>
<tr>
<td>Practice nurse</td>
<td>One</td>
<td>One</td>
<td>One</td>
<td>Two</td>
</tr>
<tr>
<td>Community mental health nurse</td>
<td>One part time practice nurse and one part time community registered general nurse unable to attend</td>
<td>All nurses who attend team meetings present.</td>
<td>All nurses who attend meetings present. Practice nurses not present.</td>
<td>One mental health nurse unable to attend, all other nurses who attend meetings present.</td>
</tr>
<tr>
<td>Attendance level</td>
<td>Mixed urban/ rural setting.</td>
<td>Mainly rural areas. Small urban mix.</td>
<td>Mixed urban/ rural areas.</td>
<td>Densely populated urban area.</td>
</tr>
</tbody>
</table>

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Being part of a team

Nurses described a range of experiences which illustrated their teams’ transformation from a very diverse group initially to a high performing team following a period of six years. Professor Brendan Drumm (2009b), CEO of the HSE acknowledged the length of time teams required to reach their full potential. Being part of a team was a positive experience for all participants. One PHN compared her previous feelings of working alone in a rural isolated health centre to the collegial support she currently enjoys:

‘I was constantly being told I was part of a team but they weren’t physical to me, when members aren’t visible they don’t seem to exist. Dieticians, speech therapists, physios, I recognized their voices on the telephone, but I didn’t have a face to put with the name. Being part of a visible team, feeling their support is the biggest thing for me’. Focus group (FG) 2

Positive influences on team development included local factors such as the length of time nurses had worked together and the strong working relationships that historically existed between GPs and community nurses. Joyce and Casey (2004) recognized the impact of these local factors when implementing support programmes for piloted teams. However, adapting to new management structures impeded progress in the initial stages of team formation. Presently, PHNs and CRGHNs are answerable to nursing management and primary care team managers. Some of the participants found this overlap confusing:

‘Having two masters is a headache. We are answerable to our nursing manager and primary care manager; one says one thing and the other another’. FG1 PHN

Conversely, practice nurses described an easier transition:

‘It was less of a hassle for us because our boss would be a GP and our manager, we were responsible to him and he was proactive towards the team’. FG2 PN

Participants stressed the value of team building programmes to team progression during the early stages of development. It united the team, improved integration and co-ordination of team skills. Nurses agreed, team members now had a greater understanding of one another’s role, as one PHN described:

‘You got to understand the role of the physio, the OT and how to integrate our skills with them,'
it united the team in working towards a common goal of bringing an accessible service to the people’. FG4

On the other hand, one team noted that ineffective facilitators impeded the initial progress of their team:

‘It depends on who you get to facilitate your team building; Some of it was useless and a waste of money’. FG3 PHN

‘Our team would have moved in a more structured way if we had a consistent team building framework, with someone to follow it through’. FG3 Mental Health Nurse

When teams have difficulty integrating it is frequently owing to inadequate team building (Cashman et al, 2004). The Institute of Community Health Nursing (ICHN, 2007) suggest knowledge gained from team building programmes undertaken by piloted teams should be applied to future training for community nurses. Practice nurses in O’ Neill and Cowman’s (2008) Irish study recommend integrating training and study days with other community nurses. This multidisciplinary approach to education would facilitate teamwork among nursing disciplines.

Interdisciplinary relationships

Irish studies have described divisive interdisciplinary relationships between PHNs and CRGNs in the community (Begley et al, 2004; Scott et al, 2006). However, in this study PHNs unanimously agreed that CRGNs formed the backbone of the community nursing service. One PHN described the core aspects of a good working relationship as:

‘Working together, communicating openly with one another while respecting one another’s opinion’. FG1

However, in this study the relationship between practice nurses and community nurses varied between teams. For example, in one team, one job-sharing practice nurse regularly attended meetings while her colleague never attended. In two other teams, practice nurses and community nurses had established good working relationships. While in the fourth team their relationship was poor and described by one PHN as follows:

‘There is little integration with practice nurses, it does affect the morale. You cannot put a name to a face, they are meant to be part of the team, it would be easier for their sakes, ours and the patient’s because we’d be integrating the service’. FG3

Literature studies from the UK have described difficulties when amalgamating state-funded community nurses with privately employed practice nurses to form integrated nursing teams (Curry and Hollis, 2002). The limited research on this topic within an Irish setting is inconclusive. For example, Hanafin and Cowley (2003) describe effective working relationships between PHNs and practice nurses while some PHNs in O’ Neill and Cowman’s (2008) study felt their role may be threatened by CRGNs and practice nurses in a team situation. What was evident during group discussion in this study was the well integrated working relationship between nurses and the other health-care disciplines involved in client care. The following example illustrates how the effective relationship between nurses and physiotherapists facilitated smooth interdisciplinary referrals, leading to rapid access to treatment:

‘We had a child yesterday with a shoulder injury post-birth. That child needs physiotherapy now, not in a month’s time, so we referred immediately, that child will be seen within a week’. FG1 PHN

‘The referral system is so much easier than the old way when the doctor referred everything’. FG3 CRGN

However, referrals to the public health nursing service were unstructured. Nurses agreed they were the only team members accepting referrals both from the general public in addition to professional agencies. Unlike other disciplines, nurses did not operate a waiting list for less urgent cases.

‘Everything comes through the door to us, we get referrals from the general public, I’m worried about so and so, don’t tell anyone, so you can’t write it down. This wouldn’t happen in any other discipline, we take everything on board’ PHN FG4

This open ad hoc referral system has a negative impact on workload management (NCPDNM, 2005; Philibin et al, 2010). In two focus groups written referrals were not regular practice and nurses knew they were losing valuable client data owing to lack of management. There was general agreement that referrals to community nursing should be written and quantified, in order to develop a comprehensive recording system. In some areas, recently established teams are now adopting a single referral form which all team professionals use (HSE, 2008b).

Nurses’ role in the primary care team

There was general agreement among all groups that the nurse’s role had not changed but had grown and expanded to meet the additional health promotional initiatives expected from a primary care team. This trend is also evident with primary care teams established in 2007 (HSE, 2008b). One PHN outlined their position:
We have to be seen to be taking on more work, PHNs, practice nurses and CRGNs. We’ve set up leg ulcer clinics, breast feeding support groups, ante natal classes, men’s health awareness, falls groups, we speak to the elderly at social meetings’. FG2

‘It isn’t enough to manage an area, we have to push ourselves to the limit, prove that it can be done’. FG2 PHN(2)

There was general agreement that management supported daily work routines over the health promotional role:

‘Management push general work, our health promotional initiatives are queried. We should have more time for health promotion but our work on the ground takes up most of our time’. FG3 PHN

Two teams were allocated supernumerary PHNs when their team was appointed.

As supernumerary, they were additional to core nursing staff. Their function involved promoting the PHN’s role within the team, providing additional support and managing complex cases. Nonetheless, when the team was launched their supernumerary status was not recognized and they were also expected to manage an area. Supernumerary PHNs found combining this dual role stressful and difficult. In general, nurses noted they were the only discipline in the team that based their work on the needs of clients in a geographical area while also undertaking the extra duties associated with primary care teamwork. In one focus group, nurses recommended they only attend clients attached to GPs within the primary care team. One PHN described:

‘I share an office with the mental health nurse and I say she is very lucky. She only sees patients of GPs in the team, writes the report and sends it back. I have everybody pulling for my time, it might be an elderly person who has fallen, a relative who has died or a baby going into care’. FG4

‘Other disciplines when they came to primary care didn’t have a geographical area, or a caseload, for us everything is added on’. FG3 PHN

‘It’s tough having a geographical area and being part of a team’ FG4 PHN

Nurses however agreed that they did not wish to change the geographical remit of their role and claimed it would be difficult to provide care exclusively to clients of GPs in the team. Clarke (2004) has argued that if PHNs were attached to general practitioner services their unique community-focused knowledge and commitment to person-centred care may be overshadowed by the more dominant biomedical treatment model. The organizational obstacles of aligning PHN geographical areas with GP practice lists was also identified by the Commission on Nursing (Government of Ireland, 1998). Firstly, GPs do not have geographical boundaries unlike PHN areas which do. Secondly, PHNs treat an entire family while a particular family may have two or three GPs looking after the various family members. Clearly, there are care issues for nurses working in a team when their work is not organized in a similar manner to other professionals in the team. Nurses also noted the time involved managing complex cases and travelling long distances was not accounted for when calculating staffing ratios. One PHN explained:

‘It’s fine saying you have a small area, but they have to look at the population within that area. I have a number of 92 year olds, my caseload is eighty plus. It’s easy to say “your area has reduced in size” but that doesn’t necessarily mean it. I am two hours in a car coming and going’. FG2

This PHN cited Hanafin et al’s (2002) model of public health nursing. This model is based on the principle that services are driven by the health needs of each area, rather than assuming areas of equal population have identical needs, requiring similar services. Nurses in this study all agreed the geographical size of an area was not a sufficient indicator from which to measure workload. The ICHN (2007) recommended that community nursing services be guided by a community needs profile. This profile should be based on a national template and undertaken by each PHN. Such a template has recently been launched in the HSE South and Midwestern regions in the Irish Republic and recommends that standardized collection of data would facilitate comparison between regional and national records (Buckley and Mulcahy, 2008).

Discussion

This is the first study in the Irish Republic exploring the experiences of community nurses working in a primary care team. Focus groups recreated an ideal atmosphere to understand individual and collective experiences of teamwork (Howatson-Jones, 2007). Many of the findings are consistent with previous research in primary care, such as difficulties associated with merging diverse lines of management when establishing new teams (Curry and Hollis, 2002; DOHC, 2004). The value of effective training on team development was also acknowledged by the HSE (2009) when it linked the successful establishment of one piloted team to early investment in team building. The quality of relationships between practice nurses and community nurses varied. Where relationships were poor, the development of community nursing services was restricted. Undoubtedly, nurses need support during the early stages of their amalgamation in order to establish a solid integrated service. Conversely, good working relationships between nurses and other health professionals facilitated direct referrals between team members.
Unfortunately, referrals to the public health nursing service remain unstructured. As a consequence of this inefficient referral system operated by community nurses, referrals are accepted without waiting lists (Begley et al., 2004). The HSE (2006) recommend cases be prioritized and a waiting list system developed. Such a system should discourage inappropriate referrals and enable nurses to organize caseloads and deliver services which would strategically meet client need.

The findings in this study illustrated the additional health promotion and initiatives associated with primary care teamwork. Moreover, nurses were the only discipline managing an area while undertaking this extra workload. If nurses are to develop their health promotional role within the team, managers should support and recognize the value of their expertise in this area. Historically, health promotion has been identified as central to the PHN’s role in primary care (Government of Ireland, 1998; DOHC, 2000). If PHNs do not develop this role their influence in the health promotional aspects of primary care teamwork will fade and may be undertaken by other health-care disciplines.

The findings also reiterated the view outlined by Hanafin et al. (2002) that services should be driven by a population’s health needs, while resources previously allocated may not reflect supports currently required. Moreover, the HSE (2006) recommend matching an area’s needs with the specific nursing skills required. Crucially, staffing ratios and nursing skills should reflect the health needs of the population served by community nurses. Precision in this area requires standardized profiling undertaken regularly by each PHN. Interestingly, while nurses acknowledged the value of skill integration within the team, this issue was not elaborated during focus group discussions. Currently, community nurses represent a wide range of disciplines from both public and private sections of the health service. Consequently, the integration of all levels of nursing expertise within the wider multidisciplinary primary care team is challenging. Nonetheless, the benefits of teamwork are considerable. Community nursing services would benefit from the establishment of a visionary framework outlining the future direction of community nursing in primary care. It is clear that primary care teams are the catalyst through which primary care services are delivered in Ireland. Therefore, it is essential that nurses develop professionally and as an integrated nursing team if they are to realize their full potential within the multidisciplinary primary care team.

**Conclusion and recommendations**

Primary care in the Irish Republic has undergone substantial reorganization since the introduction of piloted teams in 2003. It is envisaged that when fully established primary care teams will deliver 90–95% of all health and social services within the Irish Republic. This multidisciplinary approach to community care provides nurses with a real opportunity to develop their role and maximize their influence in primary care. It is hoped that the findings from this study may provide direction for the future development of community nursing within the primary care team structure. The following recommendations should support community nurses during the implementation process of future teams.

When establishing new teams, management lines should be clear and uniform, thus avoiding overlap between nursing and primary care managers.

During the initial implementation stage local factors which might impede or support team integration should be identified. Therefore, focus should be on the strengths and supporting potential weaknesses in each developing team. Team building with effective facilitators is essential to a team’s initial development.

If practice nurses and community nurses are to amalgamate successfully they need support during the early stages of their integration.

Community nurses should develop a system for quantifying referrals to their service. This would assist in determining an accurate profile of their community’s health needs. Managers could then ensure staffing ratios and nursing skills correspond to the specific care required in each community area.

When health promotional initiatives are identified additional support would enable community nurses to fully participate in these essential primary care team projects.

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KEY POINTS

- Community nursing in the Irish Republic is experiencing many changes with the establishment of primary care teams nationwide.
- Nurses require effective training and clear direction while adjusting to multidisciplinary teamwork.
- Referrals to community nurses should be quantified; this would ensure services accurately reflect the health needs of each local area.
- Nurses need additional support to manage an area and undertake the extra health promotional initiatives associated with primary care teamwork.

