Framework for success

In the final instalment of a three-part series on public health nursing we examine the use of 'dependency frameworks'

Virginia Pye

One of the greatest challenges facing the Irish healthcare service is that by the year 2020, 50% of the population in Ireland will be over 65 years of age. In a nation with a growing ageing population and rising healthcare costs, healthcare providers will have to focus now on how to manage the healthcare needs of older people. The public health nursing service is a key provider of health and social care to older adults in the community.

A study in 2004 revealed that 44% of public health nursing time is devoted to care of the older adult. The demands on the public health nursing service are set to increase as healthcare provision is redesigned to enable older adults to remain living in their own communities. From a public health nursing service perspective, improvements in the long-term management of older adults is a key priority.

The importance and the benefits of caseload management systems for the public health nursing services has been described in a previous article. In addition to the need for clear criteria on admission to and discharge from hospital to home for older adults there is also a need for a system that can reflect the dependency...
status of each adult on the PHN caseload. A dependency system adds value and understanding of the caseload for both the clinician and the manager. This article focuses on the process of introducing a dependency framework in one public health nursing service area in the republic of Ireland.

Case for dependency information for public health nursing

In Ireland, there are inadequate formal systems in place for measuring nursing workload in many community care areas. Community care workload measurement has not received a great deal of attention from nursing researchers. Workload assessment tools are categorised as either activity or dependency based. Activity-based systems allow for measurement of nursing activities, whereas dependency-based systems aim to measure patient’s needs in a comprehensive and objective manner.

Ferrant noted the benefits of having a ‘case weight’ system in community nursing; it can improve case management skills and ensure fair and equitable caseloads. The availability of dependency information has the potential to assist in defining the work of the PHN.

Many of the reports on the role of the PHN have commented on the diversity of the role and Nic Philbin refers in her article to the PHN being ‘Jack of all trades’. The PHNs interviewed for the Nic Philbin study talked about the challenges of prioritising their workload and the need to weigh acuity of need against caseload priorities. The PHN needs to be able to demonstrate in a concrete way both the quantity and the quality of her caseload. It is only when the caseload is explicit that the PHN can manage her workload, identify the caseload priorities and articulate the caseload needs.

One of the greatest challenges for PHNs, historically, has been the open nature of the caseload with no agreed caseload size and very little guidance on who to admit and discharge. Byrne commented in 2007 that a ‘waiting list’ for public health nursing service does not exist. Without these admission and discharge parameters there is in effect no workload boundary for the role of the PHN. Having a clear boundary provides the PHN with an explicit understanding of her caseload.

The decision to introduce dependency information into this public health nursing service area (where the author is the director of the service) was made within the context of the development of active caseload management and the ongoing development of primary care teams and clinical meetings. There are also the pressures of unfilled nursing vacancies due to a recruitment moratorium and this in turn is challenging PHNs to state exactly what referrals and what level of patient dependency they have the capacity to manage. Of note, there is no evidence in the literature of any dependency framework being used in clinical practice in the public health nursing service in the Republic of Ireland.

Longford and Westmeath profile

Longford and Westmeath is predominantly rural with three urban centres and a total population of 113,000. Primary care teams are in the development stage and there are three network areas. There are 39 PHN areas and each PHN covers an average population of 2,900. The recommended population size is 2,500. (Action taken in Longford/Westmeath PHN service)

The challenge for this PHN service was to identify a simple and easy to use method of determining dependency in PHN caseloads. The primary objective for the development of the framework was to be able to measure the dependency of the adult caseload of each PHN. Given the existing work pressures of PHNs it was agreed by the PHN management team in consultation with staff that a simple method of determining dependency within each PHN caseload was required. The child health/welfare and protection caseload was excluded.

Selection of dependency system for Longford/Westmeath

According to Brady, the ideal workload measurement tool for PHNs needs to be easy to use, yet measure the direct and indirect nursing care and be capable of measuring diverse care groups simultaneously. The dependency framework selected for Longford/Westmeath was chosen because it was easy to use and would allow for relatively quick retrieval of dependency information from individual PHN caseloads.

The dependency framework that was adopted was derived from the Population Health Information System. The Population Health Information tool piloted, and later introduced into, the Dublin North Central PHN service has proven to be a very functional and practical tool for assisting community nurses with caseload analysis and client dependency.

This dependency framework was adopted for use in Longford/Westmeath as it offered a clear and understandable framework of dependency ratings. This dependency framework is similar in structure to the one devised by Freeman. Freeman identified four key categories of patient care. Freeman’s model also allowed for the measurement of nursing activity time. Freeman identified benefits of the tool, namely it provided a current and detailed overview of the work of...
Table 2

<table>
<thead>
<tr>
<th></th>
<th>Low dependency</th>
<th>Medium dependency</th>
<th>High dependency</th>
<th>Maximum dependency</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total adult caseload</td>
<td>45%</td>
<td>18.8%</td>
<td>29%</td>
<td>7.2%</td>
<td>100%</td>
</tr>
<tr>
<td>Over-65s caseload</td>
<td>40%</td>
<td>29%</td>
<td>25%</td>
<td>5.7%</td>
<td>100%</td>
</tr>
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district nurses as well as having value as an audit tool. Interestingly, it allowed for greater understanding of district nursing workloads by general practitioners, which led in turn to increased district nursing hours being purchased.

The framework that was ultimately adopted by Longford/Westmeath allowed simply for dependency measurement but did not include measurement of workload activity.

The selected framework provides four care categories ranging from low dependency to maximum dependency. The descriptor for each care category provides guidance to the nurse (See Table 1 on previous page). It is accepted in the literature that district nurses may overstate the level of dependency and it is acknowledged that a degree of subjectivity is inevitable.11

Pilot phase of project

The framework selected was piloted in 2009 in three public health nurse areas and feedback on its use was very positive. Some minor changes to the dependency framework were made which included further clarification on the dependency categories. One of the pilot sites took the initiative of colour coding the clinical charts in line with the dependency status.

Applying the dependency framework to each caseload was reported to take approximately three hours for each area PHN to complete and was stated by the nursing staff to be easy to use. Each pilot area was provided with written guidance on completing the exercise and each PHN had approximately 200 adults on caseload.

Interpretation of findings

Overall, the dependency information obtained from the caseloads has proved to be very helpful. Across the total adult caseload there was a range of 2-14% of patients in the maximum dependency group with a mean of 7.2%. This compares to a similar study in Northern Ireland where the range of maximum dependency patients ranged from 1-12% with a mean of 4%.12

In the over-65s caseload there was an average of 5.7% of the caseload returned as maximum dependency (See Table 2 above). This compares with the Begley study where there was a finding of approximately 5% of maximum dependency in the over-65s caseloads.2

The Begley study returned five levels of assessed need with level five being highest and level one being lowest. The second highest level of dependency within the active caseloads of all adults within Longford/Westmeath represented 29% of the caseload. In the low-dependency category there was an overall finding of 45% in the adult caseload. When this is broken down for the over-65s years caseload the percentage of low-dependency elderly was returned as 40%.

Similarly, Kane’s study of district nursing caseloads in 2004 found a high percentage of low-dependency clients (47%). Low-dependency clients in Kane’s study were composed of clients in need of no care. It was necessary to assess and limit direct nursing care.13

Limitations of use

It is accepted that the dependency framework selected for this process is limited in that it does not calculate nurse activity and simply reflects patient dependency. However, in the absence of any dependency information within PHN caseloads in Longford/Westmeath, it was agreed by PHN management and front-line staff that this singular approach was a constructive starting point for both front-line staff and for management, providing measured dependency information that could be used for comparative purposes. The next stage in the utilisation of the dependency framework is to amend the PHN activity returns to reflect the dependency of all new referrals on a monthly basis.

Benefits to staff

Having information on patient dependency is empowering for staff and provides them with information on which to exercise their professional judgement regarding caseload management.14 This dependency information provides each PHN with a benchmark of caseload dependency and also assists with caseload management. For the purposes of comparison between caseloads it is important that a standard dependency assessment/framework is used.

Further feedback from the staff following implementation of the dependency framework would suggest that more work is required on the definitions within the care categories.

Benefit to managers

Having a clear framework of caseload criteria has been beneficial to line managers who carry out annual caseload reviews. The overall dependency information has proved very helpful to senior nurse managers in articulating the changing dependencies within caseloads and reflecting back this comparative data to staff.

The process also provides some level of objective evidence for service rationalisation. This is particularly significant and constructive in the current reorganisation and realignment of services. It also provides a rationale for reviewing caseload boundaries and redeployment of nursing resources where it is clear from the caseload that more, or indeed less, nursing hours are required.

Discussion

It is important to state that the dependency framework utilised for this project has not been subject to validation. The framework was developed to reflect the broad categories of dependency routinely found in the adult caseloads of public health nurses.

Of interest is the similarity of findings from this project to the finding of the Begley study in relation to assessment of need for the patients with highest nursing needs. Case management is an inherent element of the PHN role. According to Ervin effective caseload management is a combination of skills in organisation, time management and priority setting.15

Within the dependency framework the clients with maximum dependency by definition required case management, case co-ordination and advocacy. Case management comes under the heading of indirect nursing care. Case co-ordination is a process that encourages disciplines to work together. Some of the techniques employed in co-ordination are clinical conferences, regularly scheduled communications with other disciplines and timely feedback to other healthcare providers.16

It is this indirect care that can take up a significant amount of PHN time, liaising with other members of the multidisciplinary team and referring onwards for services. The results of this project revealed 7.2% of adults on the active PHN caseload falling by definition within
the maximum-dependency category. It is these cases that, ideally, should be identified and brought forward for discussion to the primary care clinical meetings. In this way the workload of these patients can be shared among other team members and the wider team may develop an understanding of the complexity of care required for maximum-dependency patients. In addition, the management of these cases can be shared with other team members.

Interestingly, in the UK the concept of community matrons has been introduced with specific responsibility for the management of patients with complex needs and chronic disease profiles. Case management is an excellent example of clinical leadership at a micro level. A recent report defined clinical leadership and noted that co-ordination and orchestration of care are principal mechanisms that impact on patient care.

There is good reason to consolidate caseload management skills for public health nurses as research has shown that this can lead to improved nurse morale, which in turn contributes to better staff retention and better recruitment outcomes.

In relation to the category of high-dependency patients within the framework (29% of the active adult caseload) these clients in general are of receipt of a wide range of support services but at the time of dependency assessment are stable. The likelihood is that these clients may remain stable or alternatively become unrestable and move into the maximum-dependency category.

It is unlikely that these clients will ever be discharged from the PHN active caseload, except to acute care or long-term care. The scope, therefore, for discharging patients from the PHN caseloads will derive predominantly from the low and medium-dependency category.

There was a significant percentage of the adult caseload within the low-dependency categories (45%). Traditionally, PHNs targeted this group for health promotion and health prevention activities. The challenge for the PHNs now is to assertively discharge from the low to medium-dependency categories. This is inherently difficult for PHNs who until very recently have not been required to discharge clients from their caseload. The desire to provide health promotion activities should be targeted to the wider community, based on assessed need.

It could be argued that this approach to preventative care of the elderly would be a more efficient use of nursing resources and would make explicit the role of the PHN in health promotion activities. Kane’s solution to the high number of low-dependency patients was to create a separate low-dependency caseload across several nurse areas. This meant in effect that individual district nurses could focus their work on case managing the high-dependency patients.

Irish public health nurses provide care to an adult caseload within the context of an open referral system and no explicit waiting list system. The introduction of a dependency system that supports their clinical decision-making, autonomy and clarifies the daily workload has the potential to delineate the parameters of their role within primary care.

With ongoing usage of the dependency framework and its integration into practice, PHNs can utilise this information to assist with caseload management, articulate resource needs to line management and add definition to the role of the PHN at primary care clinical meetings. Further work is required on the framework to improve its acceptability and its utility and to ensure that it interfaces more closely with the existing caseload management system.

Consideration should be given to changing the nursing model of service delivery to refocus care on maximum dependent older adults and increase the delivery of nurse led health promotion activities at population level for low and medium dependent adults.

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