



**Clinical Nurse Specialist Gerontology**  
**End of year reporting against annual work plan**

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**July 2009**

## **Introduction**

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This report identifies achievements against the Rural and Community Services Clinical Nurse (CNS) Specialist Gerontology Work plan for the 12 months of practice. The CNS Gerontology role was developed in collaboration with leaders from Health Waikato and the Aged Care Sector and reports to the manager for rural and community services. The role was developed to liaise with agencies working with older people across the continuum of care and to enhance the integration of services for older people.

## **Aims**

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The overall purpose of the CNS Gerontology include:

- To liaise between Aged Residential Care sector, Older Persons and Rehabilitation Service, Health Waikato community aged care services, Rural Hospitals, District Nursing Services and primary care sector to improve collaboration, practice standards & patient care pathways for older people in Waikato District Health Board
- To network, integrate and coordinate the WDHB/community interface for older people with complex issues in order to support and develop the continuum of care for older people
- To progress workforce development across the aged care sector

## **Strategies Impacting on Clinical Nurse Specialist Gerontology**

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There are a number of national strategies and organisational strategies the impact on the CNS gerontology role

- New Zealand Positive Ageing Strategy (2001)
- Health of Older People Strategy (HOPS)
- Guideline for Specialist Health Services for Older People
- Waikato DHB District Strategic Plan (2006-2015)
- Waikato DHB District Annual Plan (DAP)
- Health Waikato Operating Plan
- Rural and Community Services Plan
- Operational & Service plans for Rural & Community.

## **Projects Impacting on Clinical Nurse Specialist Gerontology**

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There are a number of organisational projects that impact on the CNS gerontology role

- **A collaborative Inquiry into the Puzzle of Inappropriate Aged Care Presentations to Emergency Departments, in the Waikato Region. (Moss & Walsh 2006).**

### Recommendations - Aged Residential Care

- Strengthening/further development of GP beds/specialists visiting services
- Strengthening of hospital in the residential care setting
- Ongoing development of best practice/care pathways for common problems eg infections, confusions
- Clearer/more specific pathways for referral/access to specialist skills
- Further exploration of respite care mechanisms and pathways

### Recommendations - Aged Community Care

- Further consultation/consideration of DSL/other services linkages associated with ED presentation and discharges, inpatient admission and discharge
- Continuing to strengthen District Nursing and other forms of community care/specialist treatment services/specialist older persons services

### Recommendations - Care of the dying

- Continued development of care pathways, strengthening of expert support/referral systems
- Liverpool care pathway
- Value system: Dying with dignity

- **Enhancing Registered Nurse Competency and Confidence in Working with Frail Elderly (Marra, Walsh & MacFie 2007)**

### Recommendations:

- Coordination of education and training information.
- Working with stakeholders forum, Agewise and other related networks/initiatives, advocating for consistency and inclusion, eg scope what else is needed such as introduction packages, link with PDRP and community access to this
- Progressing workforce development issues in aged care sector
- Streamline patient care processes in consultation with key groups
- Explore DHB education and library services being provided at no cost
- Explore scholarship in gerontology
- Convene a forum to discuss recruitment and retention
- Bi-annual stakeholder group workshops to supporting the resolution of issues identified above

## Key priorities 2008-2009

The following tables outline the strategic aims, objectives and outcomes for Gerontology Clinical Nurse Specialist.

Strategic Aim:	
To build workforce capacity, readiness and capability (link Nursing Strategic Plan 2007-2011)	
Key Objectives	Key Achievements 2008-2009
<p>To identify, explore and drive interventions that will increase the confidence and competency of nurses working with frail elderly</p>	<ul style="list-style-type: none"> <li>○ Networks and relationships with key individuals and forums within aged care have been developed               <ul style="list-style-type: none"> <li>Eg: Agewise (Hauraki and Hamilton), Health Care Providers New Zealand, Older Persons and Rehabilitation Service (Senior Nurses and Service Manager), Association for Promoting Aged Care Education, Advanced Gerontology Nurses Network, Local quality groups, Managers and Nurse Managers, Quality Leaders and Nurse Educators in Residential and Community Care.</li> </ul> </li> <li>○ Consultation was held with key stake holders to explore and develop an education programme for the year               <ul style="list-style-type: none"> <li>○ Eg: this included, half day workshops along side the Aged Related Residential Care (ARRC) Forum, presentation at the ARRC forum, Study days on professional issues, stroke care and in-service education on key issues, such as communication, medication management, scope of practice (50 nurses have attended central study days and 43 have attended smaller in-service sessions)</li> </ul> </li> <li>○ Barriers to accessing education, training and expertise were identified and many were resolved,               <ul style="list-style-type: none"> <li>eg The WDHB library is now open to registered and enrolled nurses working in age related residential and community care (<i>free of charge</i>), this includes electronic resources, books, journals and education training and support from WDHB library staff. Previously ARRC staff were only allowed access to printed material at an annual charge to the individual.</li> <li><b>48 registered and enrolled nurses from ARRC are now member of the WDHB library.</b></li> <li>eg: Education delivered through the professional development unit at Waikato DHB is full open (open attitude to access and provided at no cost) to staff from age related residential and community care. To date this group have attended practice development workshops (2 RNs) nurse preceptor training (4 RN's) and one is enrolled in the professional development process know as pebbles. There is a general trend towards education provided via nurse educators with Health Waikato to be provided at low cost/no cost</li> </ul> </li> <li>○ A stock take of education services available was undertaken, this revealed that unregulated health care workers are generally well supported through industry providers, the requirement for this education is in the contractual agreements between WDHB and the provider and is well complied with. The Education/training/support gap is for the Registered and Enrolled Nurse (there is no contractual requirement for "professional development" type activities to prompt the industry so this is provided on a good will basis by providers and is hunted out by RN's and EN's keen to meet their requirements under the Health Practitioners Competency Assurance Act. The target group for CNS gerontology then are registered and enrolled nurses.</li> <li>○</li> </ul>

**Strategic Aim: (continued)**

To build workforce capacity, readiness and capability (link Nursing Strategic Plan 2007-2011)

**Key Objectives**

To identify, explore and drive interventions that will increase the confidence and competency of nurses working with frail elderly

**Key Achievements 2008-2009**

- o Internet/web based applications for sharing information and supporting the sector were explored and used  
Eg a web page has been developed in the WDHB website "Age Related Care Resources" this has links to evidence based practice sites, education opportunities, policy and procedure, forms and process for accessing funding for study. This is still under development and will improve over time. Extensive use is made of email networks and newsletters to keep the sector informed of projects and processes and opportunities form WDHB and other areas
- o Key skills needed to frail elderly patients with conditions that have potential to lead to Emergency Department presentation and Hospital admission have been identified. This opens work for 2009-2010 for area such as a standardised approach to intravenous medication manage process, wound care etc. The key here is having a standardised approach to clinical conditions and treatments so communication between services is better facilitated. Also key is having mechanism to ensure standardised approaches can be communicated to all areas and embedded into practice in all areas

**Strategic Aim:**

To build workforce capacity, readiness and capability (link Nursing Strategic Plan 2007-2011)

**Key Performance Indicator**

- To promote gerontological nursing as a vocation of choice by supporting workforce development across the aged care sector

**Outcome Measures**

- Worked collaboratively with OPandRS, ARRC Facilities and Waikato DHB professional development team to identify projects that impact on workforce development
  - Eg worked with Lesley MacDonald on the development of a process for the acceptance of the first Nurse Entry to Practice Participant into a ARRC facility in Waikato region. Two facilities have expressed interested, Leslie is working with them for professional support CNS Gerontology will back up with clinical support and development. Recruitment begins August 2009
- There are now 9 Hamilton based and 13 Waihi based Registered and Enrolled Nurses and from ARRC receiving coaching from the professional development and recognition process coordinators to complete professional portfolios. Completion of portfolios in an accredited system such as this ensures these nurses do not get audited by nursing council (a stressful process), it endorses their standard of practice, helps them articulate what they do and is recognised across the whole midland region. This is an example of a standardised approach that helps raise the self esteem, self awareness and status of nursing working in the ARRC sector
- In-service and workshops have been provides around key Nursing Council documents such as Guidelines for Direction and Supervision.
- CNS gerontology has worked to introduce new Clinical Nurse Managers in ARRC to the sector networks, processes, key people, and contracts and legislation. This is slowly developing into an “orientation” style process that compliments facility orientation it has yet to be fully embedded in practice.
- Work with the professional development unit is developing a pool of nurse preceptors in age related residential and community care.
- Formal attestations have been provided to nurses CNS gerontology observes in practice to support learning and confidence.
- Coordinated a committee that organised and presented the Agewise Seminar 2009 “social connectedness” the seminar had increased presentation from research bodies and a real “feel good” factor for staff attending, feedback demonstrated peoples passion for the sector and appreciation for the body of knowledge that is developing in gerontology locally. Approximately 190 people attended the seminar

**Strategic Aim**

To Advocate for quality best practice in nursing through judicious use of evidence, research and practice development. (link Nursing Strategic Plan 2007-2011)

**Key Performance Indicator**

Assists the sector to identify clinical quality initiatives to improve standards of care delivery for clients living in aged residential care facilities and provides guidance on the implementation of agreed initiatives

**Outcome Measures**

- The Northwick Park Nursing Dependency Scale (NPDS) has been shared with the sector to support measurement of care needs, staffing to need ratio etc, the use of the NPDS has varied across the sector but includes uses such as sorting waiting lists
- Provided support/guidance/tools and education to enable facilities to response to targets identified in issues based audits  
Examples include, infection control process, multidisciplinary patient reviews, developing quality action plans, providing examples of care plans, providing in-service educations, medicine management and intravenous nursing process development/education/support.
- Best practice guidelines have been made available on the WDHB website and sessions have been organised with library staff to support age related residential and community care staff to access evidence based best practice data bases.
- The best practice communication tool SBARR (situation, background, assessment, recommendation and response) has been promoted through the sector, many facilities are using it to pass information between staff (health care workers to nurses, nurses to managers, nurses to doctors and allied health groups). Some places have made it part of routine orientation to the unit. Communication errors are the root cause the majority of incidents that cause serious harm to patients so this has the potential to impact positively on patient safety.
- Undertaking a collaborative pilot to explore the potential of an advance care planning process know as the "preferred priorities of care" There is international evidence that advance care planning impacts on presentation to emergency departments and length of inpatient stays. This pilot is being undertaking with hospice, renal, neurology and aged care so we can identify the ability of the tool to move across traditional silos. This practice initiative has the support of the WDHB Board of Clinical Governance and Health and Disability Commissioner.
- Currently working in the development of a sector wide quality group to work as a mechanism for implementing standardised evidence based best practice approaches to care. So far have endorsement of concept from AgeWise committee, Director of Nursing and a good proportion of registered and enrolled nurses from the aged care sector. This will be a key target for next years work.

**Strategic Aim**

To improve care coordination/case management across the health continuum to enhance access to health care for frail elderly people with complex co-morbidities. (link Nursing Strategic Plan 2007-2011)

**Key Performance Indicator**

Support the pro active care coordination/case management of frail elderly with complex co-morbidities

**Outcome Measures**

- Focus for this has been on systems and processes by the continued work on:
  - Development of a discharge procedure  
A standard nursing discharge letter (there are currently multiple nursing discharge letters, different for each different ward/unit) the information wanted by age related residential and community care is under development along with a standard procedure.
- Other support includes review of individual complex clients in a multidisciplinary meeting/coaching process to enhance care planning and treatment options.

**Strategic Aim**

Contribute to the planning and direction of services for older people

**Key Performance Indicator**

Develop a broad knowledge of health policies trends and directions in aged care, to contribute to service planning for older people

**Outcome Measures**

- Undertaking s scoping project to determine the feasibility of establishing a service within ARRC that will enable “acute unwell” residents to stay in place and receive a higher level of care to help them over the acute event. The aim is to avoid admissions or reduce length of stay and avoid re-admissions, to tertiary and secondary hospital.
- Next areas of submission will be on intravenous nursing care and how/if this could be managed sector wide in a standardised manner
- Feedback provided on relevant national documents such as nursing scope of practice, ambulance service review
- Participated in workforce development project focus groups