The NSW Nursing and Midwifery Office Modelling Care Project: learning about success

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Professor Mary Chiarella
University of Technology, Sydney
Nursing and Midwifery Office, NSW Health

UTS:CENTRE FOR HEALTH SERVICES MANAGEMENT

History of the Models of Care Project

- Matter first raised by the Ministerial Reference Group on the Nursing Workforce(2001)
- Next raised by the CNO’s Joint Strategic Reference Group for Nursing & Midwifery (2003)
- Commenced in 2004 – working group
- First roadshow 2005
- 2005 MoC Roadshow led to identification by clinical nurses of the need for seed funding to help them “take the step back”

History of models of care (cont)

- First Report published (NSW Health, 2006)- led to scholarship funding
- "*What we see in this report is the result of 20 years of university education for nurses*" Mr J Hatzistergos, NSW Minister for Health, February 2006
- Innovation scholarships -2006 x 9, 2007x 19 to date
- Second stage -2006 workshops and seminars
- Iterative process
- Second Report due for imminent release
- Third stage – Modelling care Reference Group

What did we decide we meant by models of care work?

> The 2004 Working Group felt that there was confusion around the term “model of care”

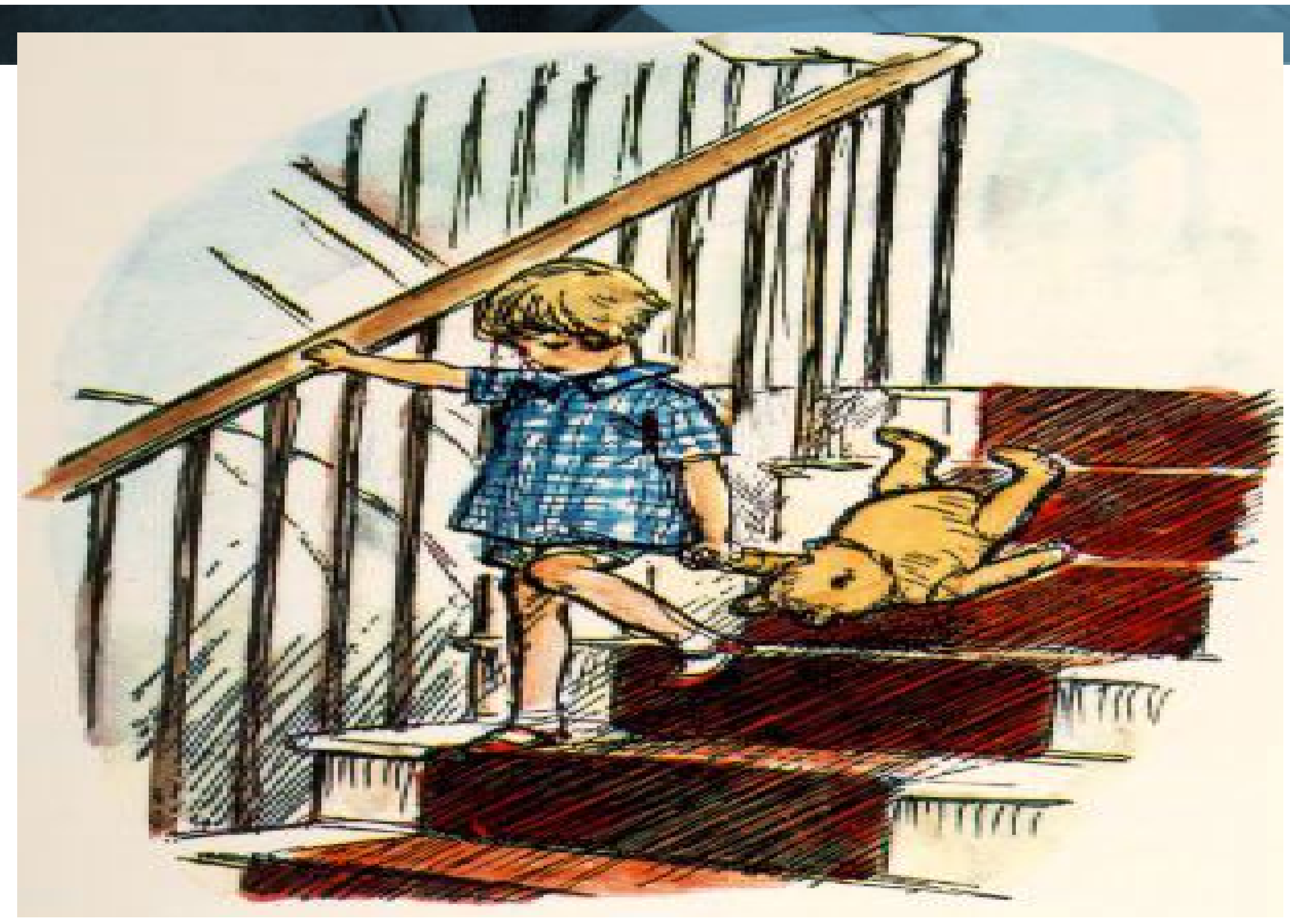
> After hearing some of the stories from people who were changing their model of care locally we agreed we didn’t wish to be prescriptive – there was to be no one correct model of care

> We agreed that we wanted to know both about care delivery practices and care organisation practices – hence “modelling care”

Original work of modelling care project

- To identify, explore and further develop innovative projects relating to modelling nursing care delivery and organisation that would facilitate best clinical practice and outcomes; and
- To develop new and emerging roles and partnerships within nursing and health care.

“As far as Edward Bear knew, it was the only way of coming downstairs, although he sometimes felt there was another way, if only he could stop bumping for a moment and think about it” (AA Milne)



What does Modelling Care work seem to be about?

Prerequisites for inclusion in the presentations

- A preparedness to reflect on and examine current practice
- Patient focus – this is the purpose of clinical nursing work
- Data – good decisions are made on good data
- Rigour – measure, observe, record
- A preparedness to try something different
- Flexibility to adapt if necessary
- Evidence of collaboration (Year 2)

Examples of modelling care work

- Reflection on and analysis of practice
- Measurement and evaluation of patient-centered outcomes
- Measurement and evaluation of staff –centered outcomes
- Implementation of evidence-based practice
- Adaptations of innovations
- Changes in skill mix
- Changes in care delivery practices
- Changes in rostering

The vision

- That clinical nurses:
- Are competent and curious;
- Are aware of their own achievements and potential;
- Live with a willingness to change and explore;
- Are positioned to maximise opportunities in the ongoing change inherent in the healthcare environment

The journey so far in 2007…

- February 2007-Modelling Care Reference Group established – nominees from all AHSs and all universities in NSW
- Sub-groups worked collaboratively to develop MoC Action Plan 2007-2008
- These groups have met regularly by phone and face-to-face to progress the work – success is not being needed any more!

Projects emerging from 2007 Action Plan

> 4 state-wide working groups to feed into and work with existing local and state-wide networks (where available)

- Communication strategy for Modelling care
- Identifying and developing support strategies for MC work
- Contemporary Nurse
- Evaluation group

Five key areas of challenge

> *Sustainability* - to ensure that no one person carries the project;
> *Synergy -* to maximise resources through linkages between clinicians and academics;
> *Synchronicity* – to coordinate work in nursing care delivery practices and organisation with research grant rounds/ scholarship applications in order to obtain funding support;

Five key areas of challenge (cont)

> *Spread* – to publish the work, and to enable people to know or at least be able to find out who is doing what;

> *Self-belief* –for clinical nurses to feel that they have the ability to improve the environment for healthcare delivery and to know how to go about it

What needs emerge from this for Clinical Practice?

> Careful clinical needs analysis and workforce planning
> Good data
> A clear understanding of how roles are defined and organised
> Values clarification, patient focussed planning (PD)
> Reclaiming or developing skills to deal with working in closer teams
> Sustainability through ownership

Where to from here?

- Obviously great motivation amongst clinical nurse leaders to improve patient care and working conditions for nurses
- Many of them already investing considerable energy in doing so
- Most of them still doing the work in isolation
- Most of them still not appreciating the value of making links with academia
- A recognised need for skills in proposal writing and data collection, analysis and evaluation
- Poor publication and dissemination rates of some of the most successful showcased innovations

What lessons can we learn ?

> Taking the step back

> Adjusting to living with uncertainty

> Being careful about how we define success

> Developing collegial generosity

> Relearning team work

> Relearning craft transfer

Taking the step back and adjusting to living with uncertainty

- It's much easier to learn new things if we have prepared for it in advance. Most people put off learning anything new at the point where it starts to feel uncomfortable. That's where the real work must be done.
- Prepare yourself to be uncomfortable. Start your learning curve early in the day while you are still alert & fresh. Resign yourself to the notion that you will not quit when the going gets rough.

Taking the step back and adjusting to living with uncertainty (cont)

- In distance running, the work is done gently - pushing your limits day after day just a little bit. The work takes a toll, and recovery is as important as the work itself.
- The breakthroughs usually occur soon after we take a step back. Rest is as important as the work itself. When we step back it's easier to see things more clearly.

> Robert Smith

> *Working outside the comfort zone*, 2000

Re-defining success

> Two main reasons why nurses leave –
  – Feel they are not valued or respected
  – Feel unable to deliver the quality of care they wish to deliver (Chiarella, 2002)
> Need to understand that routine was part of our comfort zone “at least I got my showers done”
> The 1970s/80s mentality in a 2007 world
> Jones & Cheek (2002) –”no such thing as a typical nursing day”
> If we are applying a 1980s formula to a 2007 nursing world, we will always feel that we have failed

Building collegial generosity (Chiarella 2007)

Ethos

of collective

non-
responsibility

Practice zone
of abrogation

Ethos of
collegial

generosity

Practice zone
of

mutual trust
and

Collaboration

Ethos of

Individual
accountability

Practice

zone of
isolation

or alienation

Re-defining success: re-learning teamwork

- The philosophy of patient allocation
- The current skill mix
- The casualisation of the workforce
- The level of “churn” (Duffield et al, 2007)
- How to keep the “baby” in the bath
- Remembering what we are here for and how best to do that in a time of political upheaval

Nursing is 2 things…

- The care of the sick and the potentially sick
- The tending of the entire environment in which care happens
  - (Diers 2004)

Nurses have the capability to make a profound difference to the lives of the people we touch

- The role of the nurse is to make the unbearable bearable, the intolerable tolerable and the extraordinary ordinary (Chiarella, 2002, Taylor, 1994)
- What we have to offer that is unique stems from our prolonged, intimate and regular contact with patients 24/7 – constancy, intimacy & flexibility (Chiarella, 1990)
- Our craft is an amalgam of informed clinical skill and professional compassionate care gained through a mix of education and experience
- Transferring this craft is contingent on our capacity to describe it

Craft transfer

> Every clinician here will recall an incident in your clinical practice where you gained insight when a senior clinician shared their knowledge and skill with you
> These moments are transformational, define the sorts of clinicians we become and underpin professional pride
> Craft transfer is about skills and attitudes
> BUT it is also about language to describe practice
> Experts transfer their craft out of pride and professionalism and that is what it instills
> *Ipso facto* craft transfer can only occur when people work together

In conclusion

- Our experience is that there are groups of nurses reviewing and improving practice throughout our system
- Whether they choose to do so is dependent on their local clinical leadership, their sense of self-efficacy and their ability to “take the step back”
- Whether they succeed in the long term is dependent on their organisational environment
- Whether they stay in the profession depends on how they define success (Chiarella, 2007)

Thank you

> Questions

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