

# **Counties Manukau DHB Organisational Workforce Initiatives**

**May 2010**

Executive Summary .....	4
1. Recruitment.....	5
Innovative Recruitment Solutions .....	5
Creative Candidate Sourcing: Midwifery .....	6
2. New roles .....	7
Paediatric Clinical Nurse Specialist (CNS) in Critical Care Complex.....	7
Evaluation: US Physician Assistant Role (medical model) .....	9
Matua Role: Faleola Services.....	10
Senior Pharmacy Technicians (Pyxis and Quality) .....	11
Consumer Educator/ Project Consultant.....	12
Pathologist Assistant .....	13
Breastfeeding Advocates.....	14
Medication Safety Nurse Coordinator .....	16
3. Nursing .....	17
Card Sort: Potential and Existing Nurses.....	17
Dedicated Education Unit (DEU): Enhancing Clinical Teaching and Learning .....	18
Primary Health Care Dedicated Education Unit (DEU): A Collaborative Venture between MIT, CMDHB and ProCare Health Limited .....	19
Retention and Succession Career Framework (Acute Care).....	21
Nurse Entry to Practice (NETP): Programme Extension to Community/Aged Care ...	23
Pacific Return to Nursing Pilot .....	24
Pu Ora Matatini Nursing Workforce Initiative .....	26
4. Training / Development.....	27
Organisational Language, Literacy and Numeracy Project .....	27
Cognitive Behavioural Interventions at Tiaho Mai .....	29
Gateway Programme / Medical Radiation Technologists: Radiology .....	30
Medical Radiation Technologist (MRT) Role Extension – IV Cannulation and Hookup .....	31
Non-Clinical Support Services Workforce Initiatives .....	32

Clinical Dialysis Technician Training Programme .....	34
Dual Diagnosis Team Training .....	36
5. Other.....	37
Co-location of Pacific AOD (Alcohol and Other Drug) and Gambling Team Within a Community Mental Health setting.....	37
Scope of Practice for Primary Care Key Workers .....	38
Acting Up into Different Positions, ARHOP .....	40
Surgical Services: Workforce Development in Action .....	41

## **Executive Summary**

The following report highlights a number of workforce innovations that have taken place at Counties Manukau DHB over the last 18 months. The innovations have been initiated and implemented by each individual service area mentioned in this report, and collated by the workforce development department.

The aim is to showcase and celebrate success stories, as well as to inform and inspire others considering undertaking workforce innovation, as to some of the opportunities and challenges that exist. The amount of innovation happening across different services and the community, involving a variety of different health professionals, is vast.

The summaries have been kept deliberately brief for readability purposes, but there is more information behind the innovations if readers want to find out more.

We trust that you find them informative and useful.

**Elizabeth Ryan**  
**Workforce Development Consultant**  
**Counties Manukau DHB**

# 1. Recruitment

## Innovative Recruitment Solutions

***Matt Pontin, Recruitment Manager***

Within Recruitment several innovations have occurred. They have been driven by a requirement to undertake more robust recruitment processes and methodologies. Key innovations include:

- Assessment Centre recruitment methodologies
- Social networking recruitment strategies
- Creative sourcing strategies

Assessment Centres help to condense time spent on recruitment and help to engage the business with applicants. We are now able to undertake "work sample" environments with candidates and better assess their suitability in relation to operational and behavioural based competencies (e.g Anaesthetic Technicians).

Social networking (Facebook etc) and creative sourcing strategies are driven by a candidate-short market and a more focussed and targeted approach to engaging with relevant job seekers. This also delivers cost benefits.

Staff involved include the Recruitment Manager, the Recruitment team, hiring managers, and HR/Workforce Managers.

The process has been a combination of "business as usual" as well as intense planning required for the initial assessment centre design and facilitation.

The key issue was overcoming the traditional methodology and culture of recruitment - moving the business away from standard interviews only.

The training involved ongoing upskilling of the Recruitment team (led by Manager) as well as significant training for Hiring Managers. No special funding was utilised for this projects and it was cost-negative.

Evaluation thus far has identified:

- Significant time savings (e.g Nursing Entry to Practice programme)
- Higher calibre of hire within Anaesthetic Technicians recruitment programme
- Departmental cost savings
- Positive customer feedback

A key learning is that models and recruitment approaches need to evolve to suit cross-cultural needs.

Further Assessment Centres are planned and the expansion of social media as an acquisition strategy. The key is to work as a team and utilise the expansive knowledge that already exists in the business.

**Creative Candidate Sourcing: Midwifery**  
**Neshanee Naidoo, Recruitment Consultant**

“Delivering Futures” is a creative recruitment project that has been launched recently to attract Midwives to CMDHB.

There is a nationwide shortage of Midwives and there is a business-critical need for CMDHB to increase its midwifery capacity. Hence Women’s Health in partnership with Recruitment is looking at new and innovative ways to attract midwives to work at CMDHB.

The joint project originated from the Recruitment Manager proposing a focussed campaign as well as a recruitment resource dedicated to Women’s Health, to focus specifically on recruiting more midwives.

There are two key aspects to the strategy:

“Grow our own”– this includes Return to Practice (financial support for returning midwives), Registered Nurse to Registered Midwives support, an expanded graduate programme, and targeting midwifery in the schools’ health careers promotion programme. Going forward this will also include onsite open days at CMDHB to show interested students what being a midwife is all about.

Overseas recruitment – this includes advertising in various media across the UK, Australia, and the Netherlands (comparable health systems). This includes online advertising, print media, and Facebook adverts across those countries. Traditionally the focus was on recruiting UK midwives using a relatively narrow range of media. Interviews can now also be done using Skype Webcam, reducing cost-per-hire as well as speeding up recruitment processes.

The budget for the project has come from Women’s Health, and return on investment is able to be measured, from hits on the website, through to number of EOIs and placements. 34 EOIs have been received to date.

To maximise returns there needs to be ongoing commitment from all staff involved.

## 2. New roles

### **Paediatric Clinical Nurse Specialist (CNS) in Critical Care Complex**

***Debbie Minton, Nurse Manager Critical Care Complex***

The Critical Care Complex (CCC) expanded and moved into new facilities in July 2008. Four dedicated paediatric bed spaces were commissioned due to the predicted increase in admissions<sup>1</sup>. The idea of a CNS came about due to several factors, including:

- The need to provide expert clinical knowledge and leadership on the care of the critically ill child.
- Identification of a theory-practice gap of current staff. Paediatric study days were set up in liaison with Starship PICU (4-week placements for senior nurses). The study days had been up and running for approx 12 months with about 10 nurses sent. The outcomes included competency upskilling, a work development book, and a project to work on once back in CCC. This programme was intensive and costly.
- Better collaboration with Kidz First and Starship PICU was required so that procedures and policies could be shared (seamless continuity of care).

Following team discussions a decision was made that an onsite expert was required to work alongside other staff. The expert needed to have clinical expertise to develop and lead quality care, an ability to review policies and procedures for paediatric patients, and to further develop collaborative care between Kidz First and PICU.

A business case was developed and supported by the whole leadership team<sup>2</sup>. It included admission numbers (both internal and Ministry of health predicted figures). A skill mix analysis was also completed, and it was identified that to nurse paediatric patients in an adult critical care unit was unique. It took about 6 months to get sign-off on the business case and the new Clinical Nurse Specialist (CNS) started in November 2009. Critical to the success of the business case was getting the process supported by the entire team.

The Nurse employed already had the clinical expertise to work in the scope of the role developed, so only standard CMDHB systems training was required. Funding for the salary and FTE was gained directly from the business plan (through support of General Manager).

The outcome has been very positive not only for CCC but also Kidz First EC. Staff confidence levels have also increased, through being able to access the CNS for expert advice. Further developments in policies and procedures have been continuing, supporting the continuum of care. Future plans include evaluating the new role, and creating a core group of proficient - expert Critical Care nurses with the ability to provide quality care to paediatric patients and their families.

---

<sup>1</sup> 182 paediatric admissions this year compared to 80 in the previous 12 months.

<sup>2</sup> General & Service Manager, Clinical Head, SMO lead for Paediatric Care (Critical Care), Associate Charge Nurse Manager Critical Care, Nurse Manager, Clinical Nurse Directors of Acute Care and Kidz First Medical.

The key is to be clear about the role and have evidence to back up proposed changes.  
Meeting the key stakeholders face-to-face is also beneficial.

## **Evaluation: US Physician Assistant Role (medical model)**

***Tim Wood, Contractor***

This workforce innovation is evaluating the US medical model Physician Assistant (PA) role in general surgery to assist with decisions as to whether the PA role should be introduced into New Zealand.

The idea grew out of regional work by the Northern Region DHBs (i.e Counties Manukau, Waitemata, Auckland and Northland) and the University of Auckland looking at how to deal with workforce shortages.

The project is in the development phase and is expected to be operational with PAs in place for 12 months from mid-2010. Planning for the pilot at CMDHB started in November 2009 with six work streams in the project; clinical, terms and conditions, recruitment/onboarding, risk management, monitoring and evaluation, and communications/consultation. A position description, scope of practice, and supervision requirements has been developed. Legal implications associated with this type of role have been clarified.

There are two steering groups (regional and CMDHB) with a wide range of local and regional DHB representation. The University of Auckland is partnering with the DHBs on this pilot and is having a positive input to the planning. A clinical governance group is to be put in place to provide clinical assurance and monitoring while the PAs are in place.

Issues being considered in the pilot include stakeholder concerns such as the potential impact of PAs on; reducing training opportunities, increasing workloads, and limiting roles of other healthcare professionals. These issues will be evaluated as part of the monitoring and evaluation process.

The CMDHB pilot is being funded by Health Workforce NZ (MoH), in response to a MoH request for expressions of interest for health workforce innovation ideas.

There will be an independent evaluation of the pilot, by a MoH appointed evaluator. The evaluation will assist in determining whether the PA role is suitable for widespread implementation in New Zealand.

If there is a decision to implement the PA role in New Zealand, issues of regulation will be considered then. A formal opinion has been obtained from the Ministry of Health (MoH) that the PAs in the pilot do not need to be registered.

The tertiary sector is interested in establishing a PA training programme in New Zealand but will not proceed until the health sector has made decisions as to whether the role has a place in our workforce.

One of the key learnings to date is that these kinds of projects are complex and can take longer than might be expected to achieve progress. Next steps (funding-contingent) include pilots at other sites in the Northern Region.

A key piece of advice for those seeking to implement innovations in the health workforce is to actively engage and seek the input of the existing workforce groups who could be impacted (positively or negatively).

## **Matua Role: Faleola Services**

***Natalie Leger, Service Manager, Faleola Services (Pacific Mental Health Services)***

A new Matua role has been developed within a cultural/specialist service – Faleola Service. This role provides consultation/liaison to mainstream adult mental health services, and includes work with families, cultural supervision, and cultural processes.

In order to function effectively as a cultural leadership specialist, the Matua role is vital to support Pacific models of care and service delivery. A Matua is recognised by Pacific peoples as the expert and is held in very high regard with the likelihood of improved outcomes for all (similar to the role of Kaumatua/Kuia for Maaori). A Matua is required to lead all cultural processes.

The whole team has been involved in the development of the new role, including feedback from clients/consumers. Other work drawn on came from the national Pacific workforce development organisation “Le Va”. Le Va has conducted research providing the evidence base for recognising the importance of cultural roles in clinical settings.

An internal needs analysis was completed which led to a presentation of the proposed innovation to the General Manager (Mental Health) and Clinical Director. Relevant documentation was also provided at that time. The General Manager supported this innovation and funding was provided by the Mental health Senior Programme Manager (Service Integration). A Position Description was developed and the recruitment process is now underway to hire the Faleola Service’s first Matua.

Evaluation of the innovation will occur once the new person is established in their role. Evaluation will include analysis of the outcomes for clients, families, services, and the Pacific workforce.

Key factors to the success of implementing a new role such as a Matua include communicating the vision clearly for others to understand. Providing evidence to support the project is also vital to success. Innovators also need to remain strong in their beliefs about the benefits of the innovation, provide the evidence, and ensure a good relationship and communication process is developed with key stakeholders.

## **Senior Pharmacy Technicians (Pyxis and Quality)**

***Suzy Wakim, Pharmacy Systems Manager***

***Pip Lamont, Dispensary Manager***

New roles have been created in Pharmacy – Senior Pharmacy Technician roles specialising in Pyxis and Quality.

The new roles were created to provide leadership for pharmacy technicians to support a new model of service that focuses on safety and utilisation of new technology.

During the consultation process for this new model of service, a recurring theme was a need for a career pathway for pharmacy technicians. Therefore, the new roles have introduced a clear pathway for technicians to progress their careers.

The process to create the new roles included creating Position Descriptions, advertising, recruitment and appointment, and induction to the new role. One of the new positions was established within the FTE budget, and one was created using FTE that became available due to new wards opening.

In developing and offering the new role clear expectations needed to be provided, and training offered as required. The roles have only been in place for a few months, so the innovation is still relatively new.

A key learning is that we need to think outside the square on occasion, to recognise the potential in our staff and develop our staff by challenging them to take on new roles.

Our suggestion to others looking to implement new roles would be to ensure that a thorough needs analysis has been done and if the need is established then “go for it”. Critical to success would be ensuring that the right people are recruited to the right job.

## **Consumer Educator/ Project Consultant**

***Deborah Barrow, Service Manager Mental Health (Adult In-Patients)***

***María West (Service Development and Improvement Manager – Mental Health)***

***Deb Christensen (Project Consultant/ Consumer Educator)***

This is a dual role held by a person who has experience of living with mental illness. They work alongside senior management in Tiaho Mai (the acute mental health inpatient unit) to contribute to the improvement in the quality of care delivered to clients, and to support the implementation of the Model of Care initiative. The role also contributes to workforce training and development through participation in training for clinical staff in Safe Practice and Effective Communication (SPEC) and other aspects of the Mental Health training calendar.

The concept capitalises on the benefits of utilising someone with a lived mental health experience, project management and educational skills. The objectives of the role are to ensure that the consumer's perspective is reflected within the process of developing a model of service delivery, and to support the clinical workforce in applying recovery in practice.

The key people involved included the General Manager (Mental Health), Clinical Nurse Director, and Service Manager. The Consumer Educator was employed on a two-year fixed term contract to work alongside senior management and within the Mental Health Education Team.

Some barriers were encountered in that some staff working in Tiaho Mai did not see the value of the role and felt challenged in their practice.

In terms of the individual's training needs the skills required to deliver the SPEC curriculum were provided regionally and internally. An external provider was also used when new techniques were integrated into the SPEC curriculum. The role was employed using existing vacancies within the service.

The key learnings resulting from employing the Consumer Educator/ Project consultant are to recognise the value of including the consumer voice at service development level. The DHB must persevere with addressing issues raised by consumers and model to others that the consumer voice has a significant place in service development. The importance of having clear position descriptions that reflect operational practice was also highlighted.

## **Pathologist Assistant**

***Sharita Meharry, Team Leader Histology (Laboratory Services)***

***Nigel Yeates, Service Manager (Laboratory Services)***

Within NZ the Pathologist Assistant is a person with a medical/scientific background who assists Pathologists in selecting tissue samples for processing that leads to diagnosis and patient management. Pathologist Assistants are widely employed in the US and Australia, where they free pathologist time for more specialist activities, which improves productivity.

The Laboratory Service Manager and Team Leader (Histology) developed the new role in conjunction with the Histopathologists at CMDHB. The process involved obtaining information from other Pathology Assistants around NZ. The implications and opportunities of having a Pathologist Assistant at Middlemore Hospital were reviewed with the Histopathologists and technical staff.

An issue that needed resolving was where to place the new role on the salary scale, as there is no specific scale in NZ for Pathologist Assistants. No work was required with the professional body as Pathologist Assistants are already registered with the Medical Laboratory Science Board before they resume work in a laboratory.

No additional training was required as training and supervision are on-the-job. Given that Pathologist Assistants have relevant health experience they start with some relevant training as part of their previous roles.

Funding was provided from an unfilled technical position within the laboratory. Evaluation of the Assistant role has been completed and it has proven to be a significant advantage to the department in both the technical and pathologist areas. The innovation has allowed Pathologists to concentrate on teaching registrars and technical staff to concentrate more on bench work, thereby improving turn-around times.

Future plans include potentially employing another Pathologist Assistant, especially due to increasing service demands.

When embarking on introducing a new role such as this the main piece of advice would be to communicate with services and organisations that have experience with similar positions. It is also beneficial to speak with people employed in a similar role.

## **Breastfeeding Advocates**

### ***Debra Fenton, Service Manager Primary Maternity Care***

Breastfeeding Advocates have been introduced to Maternity Ward at Middlemore as part of an initiative to support postnatal mothers during their inpatient stay. The role developed out of a combined need to support breastfeeding mothers as part of the Baby Friendly Hospital Initiative (BFHI), and support postnatal mothers as part of the Ministry of Health target to increase postnatal length of stay.

The staff involved included the Project team for BFHI, in particular the Primary Maternity Service Manager, the Project Manager and the General Manager or Women's Health and Kidz First Division.

The idea began with the commencement of the BFHI in 2008, but only got to implementation stage once the MoH required innovation to support mothers during their postnatal stay (mid-2009).

Consultation was undertaken with key stakeholders, including cultural and community groups. 2.8 FTE (community workers) were employed into the advocate role, providing a seven day a week service. They were extensively trained using a modified version of the La Leche League Peer Counselling programme, which enabled the advocates to share essential information to new mothers on infant feeding before they went home. As this is a new role and the funding is limited to one year, it is a pilot until November 2010. Assessment of the success of the role will be based on the change in exclusive breastfeeding rates for the women the advocate visits, documentation on the information shared with the women, and feedback from the women on the effect of the role.

The introduction of a new role has been a challenge. Key issues were the clarity needed around the role of the Breastfeeding Advocate and how this role was to work alongside and complement the role of the midwife and nurse on the postnatal ward. Considerable consultation was undertaken with staff before and while the role was being introduced. Lactation Consultants were present to support the advocates and staff, along with the BFHI project team. The senior midwifery team on Maternity Ward were also key in acceptance of the role on the Ward.

Three unions were involved in the initial discussion and consultation process. Their main concern was that the roles should not erode the role of the midwife or nurse on the postnatal ward. Compromise was found in clarifying that these advocate roles were for education only, and not to undertake any clinical work. Position descriptions were developed to reflect this.

Training was provided in-house, prior to the advocates starting on the ward. This was a week-long course, taught by a La Leche League trainer, based on their Peer Support Counselling programme. The cost was approximately \$1000 per head, and was funded by the MoH.

Formal evaluation of the Breastfeeding advocate role is planned for September 2010. Evaluation of women's satisfaction with their postnatal length of stay has commenced with good preliminary results.

The key to successful implementation of any innovation is to involve all key stakeholders in the decision making process. This enables all concerns to be addressed prior to the implementation phase. Any new role needs to be well defined, understood, and supported to be successful in the workplace. The success of these roles has been enhanced by the employment of Maaori and Pacific staff into these roles, who can interact with and support Maaori and Pacific mothers who use our facilities.

Formal evaluation of the role of the Breastfeeding Advocate needs to be undertaken before the end of the pilot. A decision will then need to be made as to continuing the role or not. Potentially the role could also be a community position.

One key piece of advice to anyone embarking on workforce innovation is to consult as widely as possible. Encourage people to be innovative themselves, and believe in their ability to try something different.

## **Medication Safety Nurse Coordinator**

***Derlys Jones, Medication Safety Nurse Coordinator, Quality Improvement Unit & Clinical Training and Education Centre (CTEC)***

This new role was created in June 2009. The main objective of this collaborative role is to minimise medication related incidents within the DHB, thus promoting patient safety and quality improvement within the organisation.

The key components of this position were to further develop, implement and evaluate nursing medication initiatives in consultation with clinical staff, quality improvement medication safety team and work within the spheres of the CMDHB Nursing Strategy.

This role is based in CTEC as there are clear links with clinical education from a medication safety perspective. One of the primary elements to this role on introduction was to concentrate on the implementation and clinical education with the Pyxis MedStations. Pyxis consists of an automated unit used for the distribution and secure storage of medicine in clinical areas, with added safety functions where patient's medications have been checked by a clinical pharmacist prior to administration of medicines at the bedside by nursing staff in the ward areas.

The Pyxis system has been introduced to date to 11 ward areas, ICU and 5 MedStations within emergency care. There is an ongoing roll-out plan with the aim to have this system in all clinical areas within the DHB.

Other elements of this position include:

- Development and implementation of a 5 Rights Project for the safe administration of medicines
- Raising Awareness of Medication Safety from a nursing perspective, including handover teaching and workshops on the Annual Update Day
- Supporting nurses who are having difficulty with the medication certification process at CMDHB utilising a coaching and mentoring approach
- Liaison role between nursing and operational and clinical pharmacy
- Member of the Serious and Sentinel Events (SSE) Committee and reviewing all medication errors within the DHB and actioning as necessary
- Having clear visibility in the clinical area's ensuring approachability and demonstrating leadership to nursing staff
- Reviewing of policies, protocols and guidelines that incorporate nursing practice with administration of medications

### **3. Nursing**

#### **Card Sort: Potential and Existing Nurses**

*Joanna Budai, Career Development Consultant, Learning and Development*

A “card sort” is being developed that will be used to help potential and existing nursing staff identify career options. The idea developed in response to nurses expressing a need, while completing the Career Discovery Programme (available through Learning and Development), to identify new career directions to remain engaged.

Many were struggling to identify opportunities and develop the confidence to take steps towards actioning those options. Nationally there is a drive to map career pathways within the healthcare industry. The card sort uses career mapping information in an easy-to-use exercise where nurses can identify options that would be suitable to their field of interest and personal style.

To develop the tool, information about every nursing role at CMDHB is being gathered. Clinical Nurse Directors (CNDs) and individual star performers were interviewed as part of the process. Research using various other sources supplemented the internal work i.e. DHBNZ, NZNO. This work is being done in collaboration with the Career Consultant at Waitemata DHB.

Gathering information by interviewing is time-consuming hence time to interview each person has been the main barrier to getting faster traction. The project is still ongoing, through refinement of the prototype.

The next step is for the prototype to be presented to CNDs and potentially to Nursing Council representatives. Once the card sort has been 'signed off' and accepted as a true and correct reflection of the nursing roles, user training for recruitment and management staff will need to happen. This training would be in the form of workshops.

No special funding has been allocated at this point, though once the card sort is made available to recruitment and management staff there will be some printing costs. This has been budgeted for as part of the workforce development budget.

The card sort tool brings simple solutions to issues that can quite problematic to staff members. When information is gathered primarily from a qualitative source filtering out the non-essential elements needs to occur. More interviews with role models need to occur to create staff profiles. Then feedback from CNDs can be incorporated to enable finalisation of the prototype, expected around November 2010.

## **Dedicated Education Unit (DEU): Enhancing Clinical Teaching and Learning** ***Bev McClelland, Nurse Leader Professional Development***

Dedicated Education Units (DEUs) were first pioneered in Australia - they have been the primary model for clinical nursing experience in Adelaide since 1999. This DEU project is about initiating a culture change amongst clinicians in relation to student education, and reflects both Manukau Institute of Technology (MIT) and CMDHB's commitment to improving student learning.

To implement the project it was necessary to understand the context and limitations of current practices in the clinical education of nurses and to understand DEUs as a strategy to providing superior clinical education. An extensive literature search was carried out, as well as visits to the University of South Australia and CPIT (Christchurch Polytech), where the first DEU in New Zealand was set up.

Funding was sought by CMDHB and MIT and approved by AKO Aotearoa, and the implementation of the DEUs commenced in February 2009. Stephen Kemmis's model of action research was used for the project and involved a series of cycles.

The following objectives were identified for the project:

- Document the process of implementing the DEUs.
- Evaluate the model's potential ability to support undergraduate nursing students within CMDHB.
- Make recommendations to the Collaborative Nursing Development Unit (CNDU) Governance Group on completion of the project as to the model's suitability for use in undergraduate nursing clinical education.
- Build research capacity through team research between MIT and CMDHB.

Wards 6 and 24 (Middlemore) were selected as DEUs for the first cycle of the project, based on their capacity and commitment to support the clinical learning of nursing students. Several structures were in place to develop, oversee and manage the project, including the CNDU Governance Group, Action Group and Research Management Team. The first cycle report contained recommendations that were accepted and implemented in cycle two. A third DEU in the community was added for the second cycle.

The project was externally evaluated by CPIT. Focus groups were conducted with students, staff and action group members. Interviews and other material were also thematically analysed. Sets of questionnaires were distributed to students in the DEUs, one at the midway point and the second on completion of the placement. These verbatim responses were also thematically analysed.

The first and second cycles of the research have been completed. Research to date suggests that the project has been very successful.

A key learning is that an evidence based approach is essential and it is important to consider a robust methodology to support the innovation.

## **Primary Health Care Dedicated Education Unit (DEU): A Collaborative Venture between MIT, CMDHB and ProCare Health Limited**

***Sandra McDonald, Nurse Development Manager, ProCare***

The Primary Health Care - General Practice Dedicated Education Unit (DEU) pilot began in the second semester of 2009. It provides a framework of support from an educational and clinical perspective for nursing students undertaking clinical placements in a general practice setting. The support is for both the preceptor and the student and strengthens the link between clinical and theoretical learning in a practice setting.

The DEU is a collaborative initiative between MIT and clinical partners at CMDHB and ProCare Health Limited. As part of the DEU an Academic Liaison Nurse from MIT and a Clinical Liaison Nurse (CLN) from ProCare work together to:

- Visit the students in their practices each week
- Work with the students as a group out of the practice setting
- Support students in using the MIT web-based EMIT tool
- Help the practices to support the learning environment and transfer of knowledge from experienced clinicians to students.

The establishment of a DEU in Primary Health Care (PHC) follows the two DEUs established at Middlemore in early 2009. ProCare were developing support structures for student placements hence it made sense to move forward within the DEU framework and pilot. Factors driving the DEU development include the limited number of nurses choosing PHC as an employment choice, and an increasing focus on PHC's role in managing health, wellness and illness to counteract the increasing demand on secondary health services. An expected outcome is that the number of nursing students pursuing a career in primary health care settings will increase.

There have been several challenges, including appointment to the CLN role. The CLN role has finally been filled through an internal secondment from the PHO level as opposed to PHC/ general practice level. Ideally the person should be a practice nurse employed/ seconded into the role if replicating the hospital-based pilot, however this is more complex in general practice with each practice being an individual employer of nurses.

Another challenge has been how to run the pilot when students are spread over the Counties Manukau area. Weekly visits and phone calls have been used, and a slot was established on EMIT (MIT's web facility). This has allowed for resources to be posted and it also has a chat facility.

Finally, getting all the preceptors together has been a challenge, which relates to the individual employment situation of general practice. This makes it more difficult to get buy-in for the DEU concept as they generally only see their practice view (i.e two people visiting them each week). A collective communication method needs to be implemented to address this.

Given the collaborative nature of the project there has been a lot of "learning as you go". Attending the hospital DEU action group meetings has been very useful as it has helped

the PHC DEU team to think about how some of the concepts and processes established in the wards could be altered to fit the community context.

Action research is being used to evaluate the process of developing and establishing DEU pilot sites (Ako Aotearoa). The research so far has shown some areas for improvement, include communication with and between students while on placement.

The number of ProCare practices offering clinical placements to nursing students has more than doubled (now 20 practices involved with the pilot). This corresponds with a similar rate of increase in the number of students being placed. Feedback after the first semester of the pilot was extremely positive with several practices offering placements for students in 2010 and some students coming back for a further placement or as a new graduate nurse. This suggests the DEU model is already proving its worth.

Going forward, it would be great to be able to continue with the concept and roll it out to other areas in the DHB, including other PHOs and community-based providers. For this to happen there needs to be someone to promote the concept, and start the implementation. There would also need to be funding for CLNs from different areas of PHC.

## Retention and Succession Career Framework (Acute Care)

*Annie Fogarty, Clinical Nurse Director Acute Care*

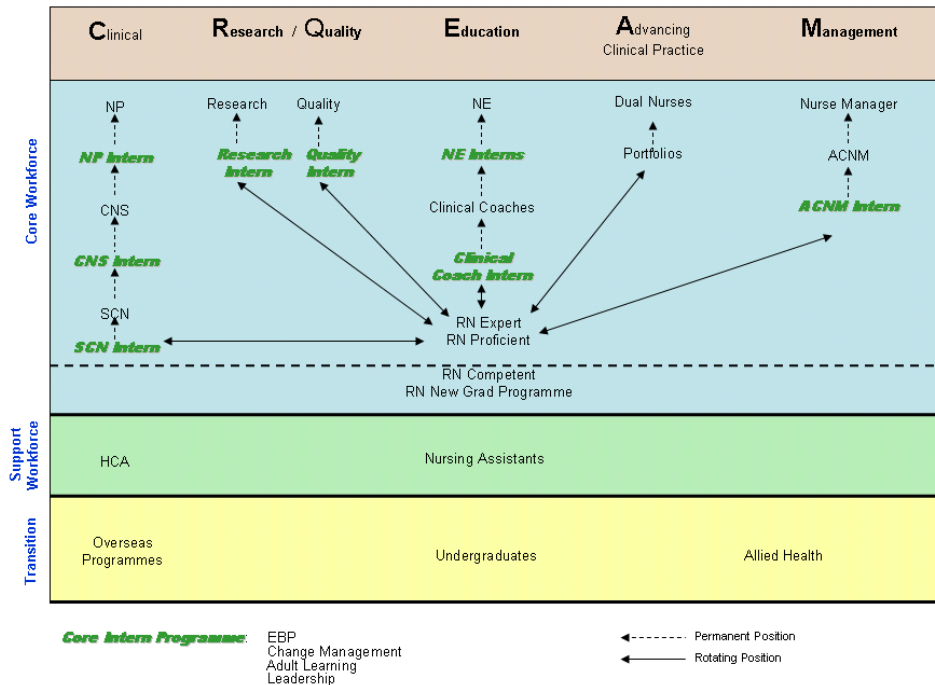
*Mary McManaway, Nurse Manager EC*

*Debbie Minton, Nurse Manager Critical Care Complex (CCC)*

A retention and succession career framework has been developed for nurses working within the Acute Care Service. Historically, the advanced career pathway within Acute Care has centred on obtaining a Charge Nurse position. The introduction of new roles in clinical, education, research and advanced clinical practice provide wider career opportunities. However, coinciding with this expansion in options, nurses may experience more confusion as to what career pathway to take. International trends also indicate current and future difficulties in retaining nursing staff in speciality areas, such as EC and ICU.

The Model (pictured below) provides a number of career pathway options highlighting recommended clinical and academic requirements that provide appropriate support and guidance to nurses to enable them to achieve their professional goals. One option focuses on senior nursing development with each progressive career step providing a rotating internship programme that allows the nurses to experience what the selected role entails. Alternatively the CREAM<sup>3</sup> combination provides formal recognition for nurses who do not necessarily wish to take a permanent senior role (or have completed their internship programmes) the opportunity to continue to develop their skills at an expert level.

ACUTE CARE CREAM – RETENTION/SUCCESSION PLAN



<sup>3</sup> CREAM describes the different routes: Clinical, Research or Quality, Education Advancing Clinical Practice, Management. We would like to acknowledge Waikato DHB Nursing staff for allowing us to adopt the word CREAM and adapt the concept.

This project has been led by the Unit Nurse Managers and the CND, and began in November 2008. The process used is a Participatory Action Research (PAR) approach, and it is continuing as new roles are implemented and feedback is evaluated. Steps have included a literature review, consultation with senior medical and nursing staff, piloting nursing intern roles, developing job descriptions and competencies that inter-link with career progression, and developing interdisciplinary education and training programmes.

Nurses have worked closely with other staff, such as Service Managers and Medical staff, who have been very supportive of this innovation. Senior nursing and medical staff have been utilised to help develop formal and informal education and training programmes. As permanent roles have been established (e.g SCN positions for nurses who have completed the internship programme) they are helping to train and educate new interns.

The project is being continually evaluated using a variety of processes, including formal and informal feedback from participating nurses and medical staff. Learnings have been shared between ICU and EC and the framework has been adapted to suit the different professional cultural and educational needs.

A key challenge has been the need to adapt and develop the concept as there was no blueprint to follow and overseas centres have different cultural and legislative requirements. By taking a PAR approach the process has also been longer (consultation), but the benefit has been overwhelming support for the concept.

Key factors in the success of the rollout include:

- Piloting the concept first (starting small) means nursing and medical staff confidence in the programme is high
- Improved patient outcomes - there has been visible improvement in the delivery of care to patients and improved teaching and education throughout the service
- An interlinked approach to developing competencies ensures nurses are clear about expectations

Moving forward roles and job descriptions are continuing to be developed in response to patient population needs. There is also consolidation of the education and training programme in clinical practice, as well as ongoing monitoring of the effectiveness of the roles e.g. number of patients seen by CNS on a daily bases. The Acute Care team are keen to support and share the new framework and leanings with other interested services within the DHB (interest has already been expressed). Finally, there is ongoing tracking of retention rates and cost savings associated with implementing the framework.

## **Nurse Entry to Practice (NETP): Programme Extension to Community/Aged Care**

***Karyn Sangster, Nurse Leader Primary Health***

The Nurse Entry to Practice (NETP) programme for new graduate nurses has been extended into the community and aged care settings. This has been driven by the recognition of the need to attract and retain new graduate nurses in settings outside of the hospital. The innovation has included the Primary Health Care (PHC) Nursing Team based at Lambie Drive, with support from the Nurse Entry to Practice team.

The NETP programme has been piloted in the community from 2005 with fully-funded positions in general practice. In 2008 the Clinical Training Agency (CTA) launched a national initiative through DHBNZ to introduce the programme in the wider Primary Health Care Sector. This included Aged Related Residential Care and General Practice. An expression of interest was responded to by CMDHB to be a pilot site and funding given to employ a Nurse Coordinator for a 12 month contract to set up the programme and gain accreditation from the New Zealand Nursing Council.

In terms of barriers the transition from a fully-funded placement to a partially subsidised programme was thought to be a barrier, but this has not proven to be the case. The programme now differs in that the new graduates are employed directly by an employer so the DHB role has lessened. Some employers were initially concerned with the ongoing mentoring support from the PHC nursing team, but this is overcome by setting clear boundaries and expectations.

Recruitment is ongoing and undergraduate nurses at local education providers are made aware of the opportunities available to them prior to their graduation. The PHC nursing team lecture to undergraduates and also attend open days and related events. Increasing student placements is a key component to ensure that the student nurses experience PHC. The NETP expansion programme includes the same postgraduate education components as the NETP hospital programme.

CTA funding was utilised for the first year for the Nurse Coordinator position. The new graduate positions are subsidised through the Director of Nursing and workforce development. Evaluation forms are completed by the new graduates at 3, 6, and 12 months. This is coordinated by the hospital team when they meet with the graduates at education sessions.

A key learning is that one-year positions to set up programmes are difficult if not transitioned completely. Since the Nurse Coordinator completed his contract it has been difficult at times to absorb this role into a team with already fulltime roles.

Graduate positions have increased by 100% this year due to the availability of positions in the sector, which in turn has reduced the subsidy for the employers. This has not been a barrier to finding positions for the new graduates. We have also recruited our first two new graduates into the Aged Care Residential Sector.

A key piece of advice is that new roles created to support workforce innovations need to be sustainable and embedded into the workforce.

## **Pacific Return to Nursing Pilot**

***Esther Faitala, Pacific Workforce Development Programme Coordinator***

This pilot supports Pacific-trained and registered nurses to obtain their New Zealand Nursing Council (the Council) registration. All overseas-trained nurses have to successfully complete the following requirements:

1. An English language test from either: the International English Language Testing System (IELTS) academic test with minimum scores of at least 7 in listening, reading, writing and speaking, or the Occupational English Test (OET) with a B in each section.
2. Complete a Competency Assessment Programme (CAP).

Given the ample evidence showing high number of Pacific Islanders with poor health status because of the various social determinants of health, the pilot is one of the initiatives driven by CMDHB to increase the Pacific health workforce to address this issue. There is a significant shortage of Pacific health professionals, particularly in the Counties Manukau area (largest Pacific population). By supporting Pacific-trained nurses, many of whom have years of clinical experience and a strong understanding of Pacific cultures, workforce development aims and better health outcomes can be realised.

Having more Pacific health workers also addresses some of the cultural barriers Pacific people face when accessing health care services. Barriers include: language, understanding Pacific values and protocols, family/ cultural structures etc.

A variety of people have been involved in the pilot. At the macro level this includes MIT (School of English, Nursing Department), and within CMDHB the Director of Pacific Health, Director of Nursing, Nurse Leaders (Maaori and Pacific), and Nurse Educators. At the micro level there has been a lot of support in the pilot recruitment process from key members of the Samoan Nursing Association, Fiji Nursing Association, referrals by other nurses and health providers.

The pilot started in May 2008 and is due to end in June 2010. The first cohort consisted of 30 students and the second cohort consisted of 32 nurses. The pilot has 2 phases:

1. Phase One consisted of undertaking IELTS lessons/ exercises which took place at MIT's School of English to strengthen writing, speaking, reading and listening skills. To pass IELTS each student has to score a minimum of 7.0 in all 4 modules of listening, writing, reading and speaking.
2. Upon successful IELTS results the students then undergo Phase 2: a 12 week CAP programme. At present we have had 2 groups of 6 and 7 nurses complete their CAPs course. The first group did CAPs with MIT and second group at ADHB.

In terms of barriers the documentation requirements and timeframes have been onerous, as outlined below.

1. Nursing Council documentation - A complete Council application is required in order to receive a decision letter that allows student nurses to commence CAP after passing IELTS. Application documentation includes original transcripts, original verification of registration, and original police clearance certificates. These can only

be obtained from their home countries which may take months to receive as fees may be involved to release them and in some countries original verification can only be released on particular days of the year.

2. Timeframes - Expiry dates for Council applications are 18 months, and IELTS results are only valid for 12 months. Managing work permits/ visa expiry dates is also a challenging factor.
3. Employment - The possibility of the nurses not getting jobs at CMDHB once they become Registered Nurses post-pilot.

There has been ongoing interaction with the Nursing Council around ensuring the pilot runs smoothly while still meeting the necessary requirements. For the purpose of the pilot the Council has allowed CMDHB to obtain original documents such as academic transcripts and police clearances, and courier documents to the Council on behalf of pilot nurses. As a DHB Counties has also been able to act as agents on behalf of the pilot nurses in requesting certain actions (e.g extension of applications until the end of the pilot).

The DHB has worked closely with MIT to deliver and facilitate both phases of the pilot and the experience has been positive. Funding was also provided from MoH, and a formal evaluation is due to be completed later in 2010.

In terms of key learnings there is a much greater appreciation of some of the barriers encountered by overseas-trained health professionals in meeting NZ standards. There are not only procedural barriers in some cases, but also motivational barriers too (e.g in having to sit IELTS multiple times).

The next steps are to group the nurses according to where they are in the registration process. From the pilot list of nurses they will be divided into the following groups:

1. "Pre-Competency" group are those who have passed 2 or 3 IELTS and will have an intense IELTS session for 4-6 weeks (with different learning approaches), re-sit, and then hopefully undergo CAPs in May.
2. "Redirect" group are those nurses who will take longer to pass all 4 modules of IELTS than others so these nurses will have to look at other options (with the support of CMDHB) where their skills and experiences are best utilised. e.g community health worker, health promotion, oral health.
3. "No response" group are those who have not contacted and/or responded to CMDHB regarding their status in the pilot.

A key piece of advice with respect to managing this type of pilot is to have patience - the nurses will get there but the unknown part is *when*.

## **Pu Ora Matatini Nursing Workforce Initiative**

***Dolly Rewha, Maaori Nurse Director Te Kupenga o Hoturoa***

Pu Ora Matatini is a nursing workforce initiative (originally established in 2007) by Te Kupenga o Hoturoa Primary Health Organisation (TKOH), a Maaori-led primary health organisation in Counties Manukau, in collaboration with Manukau Institute of Technology (MIT), Ministry of Social Development (MSD), CMDHB and the Ministry of Health.

The objective of the programme is to address the need for more Maaori primary health care nurses in the Counties Manukau area by training at least 100 Maaori nurses by 2014. Although Maaori make up around 20 percent of the local population only 5 percent of the total registered nursing workforce across NZ identify as Maaori. Capable and competent Maaori nurses are essential to providing culturally safe and appropriate care to Maaori and their whaanau (particularly those who access primary health care). The provision of such care impacts on the improvement of wellbeing for Maaori in the region.

The Pu Ora Matatini programme offers:

- Financial support (conditions may apply)
- A dedicated programme coordinator/kaiwhakahaere
- An extensive support network and Whaanau learning environment
- Mentoring and guidance, tutoring support
- Practical placement / Job placement (on successful completion of degree studies)
- Cultural Support which also includes Tikanga and waiata training

Potential nursing students are enrolled in the School of Foundation Studies at MIT to complete a two-semester pre-degree nursing course. Successful students then go on to complete the Bachelor of Nursing degree. Students can remain on the Domestic Purposes Benefit (DPB) throughout their education, and all course costs are paid. There are two intakes a year, in February and July, each with a maximum of 22 students.

Although providing the funding and infrastructure for this programme has been challenging, these challenges are insignificant compared with the challenges facing the students.

Going forward the Tindall Foundation has agreed to fund an extension of the Pu Ora Matatini programme to include midwifery for the next two years. As at February 2010 there were 70 students enrolled in Pu Ora Matatini to complete nursing training (varying stages of completion) with a further 12 to be confirmed into the Midwifery programme.

## 4. Training / Development

### **Organisational Language, Literacy and Numeracy Project**

***Anne Marinelli-Poole, Organisational Learning and Development Manager***

Planning is underway for a range of Language, Literacy and Numeracy (LLN) initiatives across several CMDHB workforce groups. CMDHB's workforce is one of the most culturally and linguistically diverse in the New Zealand health sector and associated with this diversity are varying levels of LLN skills. Low LLN skills can affect a person's understanding and enjoyment of their job which can lead to:

- Communication problems across a wide range of areas
- Quality compliance issues such as documentation and production errors
- Taking longer to become familiar with new technology
- Low staff retention and high absenteeism
- Difficulties with understanding health and safety compliance and requirements

The idea developed from initial work which was undertaken with the cleaners and orderlies. Other drivers include known learning gaps, organisational development issues and identified organisational risks in patient care.

The strategy development project is led by a steering group including the Organisational Learning and Development Manager, Director of Nursing, GM ARHOP and the Non-Clinical Support Manager. There are a range of people/sectors involved in stakeholder consultation.

The process began as a pilot programme with the cleaners and orderlies. This was followed by a 'community of interest' discussion, workplace observations and current and future state workshops which have informed development of an organisational strategy and action plan. The action plan will focus on three key areas, nursing/health care assistants, aged care, and cleaners/orderlies across a three-year staged implementation. It will also align with quality improvement initiatives in these areas.

A key challenge has been getting people to understand the meaning of language, literacy and numeracy (LLN) in the context of health literacy; recognising that the LLN lens must become embedded into business as usual.

Training and education is required to build the capability of the existing workforce (particularly educators) to embed these skills in practice and for resource and plain English document development. Outcomes to date have been excellent, engagement is encouraging.

Funding has been received from the Department of Labour to support the strategy and action plan development; from the Tertiary Education Commission to fund the pilot with the cleaners and orderlies and further work as outlined in the action plan.

An evaluation of the pilot will be available shortly. The evidence to date clearly confirms the need for this work, the value the employee places on it and the positive impact it has

for the organisation. A key piece of advice is to have a very clear understanding of what LLN means, what a project of this nature is about and to be able to communicate it succinctly.

## **Cognitive Behavioural Interventions at Tiaho Mai**

***Anna Elders, Clinical Nurse Specialist in Therapeutic Interventions, Tiaho Mai***

This workforce innovation is about attempting to 'embed' cognitive behavioural interventions (skills in talking therapies) into Tiaho Mai (the inpatient mental health unit) through teaching, supervision, modelling and developing a structure for support and development. This project aims to increase access to talking interventions for clients as well as increasing 1:1 time spent and improving overall care within the inpatient unit.

This project has arisen from the MOC (Model of Care) project and the Service's absolute commitment to enable and support the workforce to deliver interventions aimed at assisting in empowering clients to recovery. It fits alongside other initiatives such as Te Pou's Talking Therapies project.

The staff involved included the Clinical Nurse Director, Service Manager and Clinical Nurse Specialist (Therapeutic Interventions).

The project commenced in April 2009 and will continue for the foreseeable future as it develops. A four-day training programme was written for nursing staff and is currently being delivered. A research project is developing to evaluate the impact on staff recovery attitudes and behaviours and client recovery attitudes and behaviours.

The main challenges have been organising staff cover on the wards in order for nurses to attend training and supervision and helping staff consider how to incorporate more 1:1 interventions with patients during their already busy days.

Currently the ethics approval for the research component is being written and when approval has been given data collection will commence. To date verbal feedback regarding the impact of training on staff has been very positive.

One of the key learnings is that maintaining focus on a change project from a large team is an ongoing task which needs to be built into the planning element of the project.

The next steps are to complete training of all staff, embed supervision clinics to support use of the skills in practice, and review barriers to staff providing more talking interventions with clients.

For this type of project it is advisable to find a mentor who has undertaken a similar project before to ensure appropriate support and supervision in order to manage the obstacles that inevitably arise within the service, and ensure that the timeframes and goals are reasonable and realistic.

## **Gateway Programme / Medical Radiation Technologists: Radiology**

### ***Beryl Kelly, Charge Medical Radiation Technologist (MRT), Radiology***

This workforce innovation is centred on the Radiology department's involvement with prospective Medical Radiation Technologists (MRTs), both with school students and potential trainees looking to enrol in the tertiary training course.

The Gateway programme is a secondary schools' programme aimed at giving senior students structured workplace learning, while still at school. Radiology are giving Year 13 school students a view of what Radiology staff do, with the aim of exposing young people to the work, and seeing if it's a career that might interest them.

The programme has been a joint initiative between Manurewa High School (Gateway Coordinator) and the Radiology Department, and students come to Radiology for one day every week for 4-6 weeks. The main activities that need to occur to enable the programme to happen are matching suitable students with suitable timeframes and staff availability. The students are expected to behave as employees would while at the DHB, including respect for patients' privacy etc.

In order to implement the programme discussions have been required with MRTs as to the relevance and benefits of the students attending, and also the involvement they are expected to have.

Student feedback regarding the programme has been positive with those attending finding the visit to be very informative. Students now have a wider appreciation of jobs that Radiology has to offer (this also holds for Radiology staff too). The programme is ongoing with more opportunities being offered in 2010.

In terms of advice to others looking to implement this type of programme it is important to have clear communication and to ensure that all parties are aware of both the expectations and limitations.

### **Pre-training visits**

Candidates who are interested in enrolling for the MRT course are required to visit a Radiology department and observe qualified staff performing their role across all modalities. Positive feedback has been given that this is a valuable experience to ensure an accurate understanding of the person's career choice prior to being interviewed for a place on a training programme. On acceptance to the programme the students arrive better prepared for the clinical component of the course.

## **Medical Radiation Technologist (MRT) Role Extension – IV Cannulation and Hookup**

***Alison Goodare (CT Grade MRT) & Beryl Kelly (Charge MRT)***

Selected Medical Radiation Technologists (MRTs) working in CT and MRI are now trained at CMDHB to IV-cannulate and administer contrast during examinations. This role extension was initiated to improve work flow in CT and MRI and reduce interruptions to other medical staff.

A large proportion of procedures performed in CT and MRI require the administration of contrast so it made sense to train interested MRTs. This practice is already commonly established in private practice. Role extension has not required the MRT registration board to be involved. However, there has been a lengthy process to gain approval internally at CMDHB. The Clinical Board has endorsed a protocol to allow the MRTs acceptance onto the IV Cannulation training programme and a special dispensation to allow for a narrow frame of prescribing so that MRTs can attach patients to an IV contrast pump and administer IV contrast in adult patients.

In terms of training, IV cannulation is performed following the CMDHB guidelines with sign-off on 5 insertions by the radiology Clinical Nurse Educator or radiology nurses who have completed their preceptor requirements. Once the IV cannulation requirements are achieved the MRT completes a medication workbook that is specific to contrast and is reviewed to ensure understanding by the individual. This is followed by a practical assessment with a consultant radiologist.

Not all MRTs are trained in cannulation or administering contrast - it is not compulsory for staff. However, the MRTs who have taken on the role extension have found this learning experience rewarding and an opportunity to develop new skills in their profession.

## **Non-Clinical Support Services Workforce Initiatives**

### ***Clare Thompson, Non-Clinical Support Manager***

With several key support services recently moving “in-house” the Non-Clinical Support Service has embarked on a suite of workforce development initiatives that are focussed on delivery of improved customer service and are in line with the DHB’s values. In particular, the aims are to enhance the patient experience by improving service delivery, to reduce patient harm, as well as to upskill staff and giving more variety to their roles. The key initiatives, include implementation times, include:

- “Good 2 Great”: Delivery of exceptional customer service - rewarding consistent behaviours in line with Service's vision and values (3 months from idea formation to management team and staff rollout).
- Standardised Cleaning Methodology: Development of a standardised cleaning approach in 3 different languages and in a visual prompt format to detail the method and equipment used, incorporating the 5 moments of hand hygiene (9 months from identification of the need for standard methodology to the trial ward and finalisation of documentation).
- Workplace Literacy: Recognising that a number of CMDHB workers are ESOL (English for speakers of other languages), there was an initial needs analysis carried out to determine the ESOL needs, low literacy needs, and supervisor literacy needs (12 months from needs analysis through to pilot programme implementation with staff). This work is substantial and ongoing.
- Victorian Standards: This has given CMDHB a tool to measure hospital cleaning performance against national and international cleaning standards. Supervisors have been up-skilled to undertake these audits (15 months implementation time).
- EC 6 Hours Coordinator: Implementation of an Orderly Coordinator role over a 24 hour period, and a fixed permanent team of Orderlies developed to solely look after the needs and requirements of EC.
- Radiology Coordinator: Coordinator position to manage the flow of Radiology patients and dedicated Orderly team, thus reducing the wait times for patients and improving the down-time for Radiology staff. Communication was improved by the introduction of mobile phones, increasing the flow and reducing time spent locating orderlies.
- Performance Development Reviews: During the transition of services back to the DHB it was identified that staff within the cleaning and orderly department had not been involved in a performance development review process for many years. Non-Clinical support worked with HR to develop a competency matrix for the roles and develop documentation appropriate to the roles. Training sessions were delivered to all Team Leaders and Supervisors who would be carrying out the appraisals and sessions were held with all groups of staff and unions to explain the way forward (4 months implementation time).

The initiatives have been largely driven by the Non-Clinical Support team over the last 18 months. For the Workplace Literacy programme MIT was also involved. The initiatives have been well received by senior management, through to ward staff and the

Non-Clinical Support team as a whole. The end result is a more motivated and engaged workforce, and a greater awareness from the Non-Clinical Support staff that their roles contribute directly to patient outcomes.

In terms of working with professional bodies, in order to implement the Victorian Standards there was interaction with the State of Victoria Health Department. Other challenges included dealing with “red tape” and delays, and the time commitment required by team members.

In terms of training and education the need for a Non-Clinical Support Trainer was identified early in 2009 and the role of Training Officer was developed. All in-house training has been provided for by this role except for Workplace Literacy (which was delivered by MIT and funded via central government).

In terms of evaluation, audits undertaken are showing a vast improvement in cleaning standards throughout the hospital following implementation of the Victorian Standards. All other initiatives will have a formal evaluation carried out when implementation is complete.

A key learning has been that the method of training delivery is critical. The formal classroom style teaching does not suit most of the non-clinical support staff involved. The method used to deliver the training is very visual and it allows for interaction (e.g “show and tell”). Time also needs to be factored in to confirm that the learning has been absorbed.

In terms of future plans “Good 2 Great” is expanding so as to take it to the next level. For the “7 Steps” the next stage is the introduction of colour coding of equipment, which is internationally recognised as overcoming language barriers (funding-contingent). For the Victorian Standards the plan is to continually improve standards with the aim of meeting the required benchmark of 90-95%.

Aims need to be well defined in terms of what the innovation is going to achieve. Wide consultation ensures staff buy-in for the initiative and helps measure the success of an initiative. Finally, adequate investment of both time and resources is required at the start to get initiatives off the ground.

## **Clinical Dialysis Technician Training Programme**

***Dannis Moses, Professional Advisor, Renal Services***

A CMDHB business case put forward in 2005 forecasted a haemodialysis growth rate of 11%+ in the Auckland Metropolitan Region. As a result the availability of staff with the required skills is predicted to become a limiting factor. A workforce expansion of approximately 8 FTE per annum is predicted across the Auckland region, which represents an increase of 2-4 technicians per annum.

The primary focus of the Clinical Haemodialysis Technician is to perform haemodialysis treatment for patients with end-stage renal failure, and to provide technical expertise, equipment monitoring, and machine maintenance.

A one-year training programme was designed to prepare trainees for the Clinical Haemodialysis Technician role. It provides a clinically focussed educational opportunity that fosters the development of the clinical and theoretical knowledge/skills necessary to perform haemodialysis. This programme requires trainees to apply theory to practice, particularly in regard to the management of patients and the maintenance and monitoring of dialysis equipment, as per the requirements of the New Zealand Board of Dialysis Practice (NZBDP).

### **Combined Training Programme by CMDHB and ADHB**

In 2008, The National Renal Advisory Board (NRAB) identified establishing a nationally coordinated renal technician training programme as one strategy to ensure adequate numbers of renal technicians to meet the growing demand for dialysis. A national renal service improvement project was initiated in conjunction with The Clinical Service Development Team (CSD) in the Sector Capability and Innovation Directorate (MoH).

It was felt desirable for quality care of the varied client group on dialysis in New Zealand to have a mix of technicians, including some who are locally trained. Having a nationally coordinated course appears to be an efficient way to provide comprehensive and consistent training to a small group across several sites.

As CMDHB and ADHB both already intended to train two technicians each, it was suggested that the DHBs run a combined renal technician training course in 2009. The course would be under the supervision of the NZBDP and would be based on the curriculum and associated material created by the NZBDP. The NZBDP would ensure the local site facilities were adequate, monitor progress of the course, and provide advice (as required) to ensure its success.

The combined course was designed to share the study days and tutorials but the clinical hours are within respective DHBs, due to different clinical settings. CMDHB already has a haemodialysis trainer employed and a Professional Leader (who is also the training programme coordinator). The tutorials are mainly provided by the training programme coordinator and some are shared with ADHB. The programme will be completed in May 2010 at which point an evaluation will be carried out both by CMDHB and NZBDP.

## **National Training Programme**

Running a combined course would provide a model which could be promoted to other DHBs interested in renal technician training. It could be a prelude to a national course (in which CMDHB and ADHB would be the largest players). As part to the renal service improvement project the Ministry CSD team is keen to explore the pros and cons of this with CMDHB and ADHB, and ways it might work in practice, as a step towards a nationally coordinated course.

Going forward, in moving towards a national programme it would make sense to have the tutorials provided by a tertiary institution. The programme could be broken into three different but interrelated components: theory base, workshop practicum at DHB level and then a clinical placement with preceptors. A tailored block course or an online study on the theory base conducted by a tertiary institution would be a prelude to running a Certificate and possibly even a Diploma course. It would also provide opportunities for senior staff working within DHBs to be involved in lecturing at the tertiary institutions, and develop a new career pathway for the workforce.

Tertiary institutions have been contacted but are already committed towards their tailored courses, furthermore to tailor a block course for 4 students appeared financially non-viable.

## **Dual Diagnosis Team Training**

***Deborah Barrow, Service Manager Mental Health – Adult InPatients  
Toni Bowley, Manager Altered High Youth (WDHB)***

This initiative is about specialist workers in mental health and substance misuse (dual diagnosis) from Waitemata DHB working within CMDHB's community mental health team to support the staff to work alongside these clients presenting with both a mental illness and substance misuse (dual diagnosis).

The project has been driven by Ministry of Health guidelines which identify that mental health staff need to be able to work effectively with people suffering from mental health issues and substances misuse. The main staff involved have been the General Managers, Service Managers and Clinical Directors from both DHBs.

This was a 2-year project set up to provide specialist dual diagnosis workers from WDHB to work in CMDHB services (3 FTE). WDHB specialist staff also provided "whole team" training to CMDHB staff around working with clients who use substances. Training was provided across the teams by staff from WDHB - this "whole team" training was completed over a number of weeks.

The main issues related to the staff policies/ procedures across the two organisations, which differed. A steering group was established to assist with resolving issues.

The REAMHS team (Research, Evaluation and Audit for Mental Health Services) is in the process of evaluating the project. Some of the challenges include working across DHBs, HR policy issues and procedural differences. The sustainability of the project also needs to be secured.

The next step will be to feed the evaluation results back to the teams once completed.

The main learning is that when working across different providers there needs to be a clear understanding of respective teams' roles.

## 5. Other

### **Co-location of Pacific AOD (Alcohol and Other Drug) and Gambling Team Within a Community Mental Health setting**

***Natalie Leger, Service Manager, Faleola Services (Pacific Mental Health Services)***

An innovation in community mental health settings has seen the co-location of a Pacific AOD and Gambling team within a community mental health setting. This innovation has led to improved interagency/sector collaboration, referral processes, care planning, and strengthens the Pacific workforce.

Discussion has been underway for several years about improving the relationships across the mental health and AOD sectors. This co-location realises that vision and improves the client pathway. Co-location of services also provides increased opportunities to support the Pacific workforce through joint clinical and cultural initiatives.

The staff involved are from two DHBs (Waitemata and Counties Manukau), including respective General Managers, Service Managers, Business Analysts and Facility Managers. The idea was actively supported in 2009 by two Service Managers with mandate and support from the GMs. Facility managers worked closely with service managers to address details such as: facility reviews, lease agreements, room preparation, and moving day coordination. Implementation took about 5 months.

The main challenge was coordinating the key stakeholders – multiple service liaison/interface meetings occurred to implement the project. No formal evaluation has taken place but to date feedback has been very positive from both teams. Client feedback is yet to be obtained.

Future steps include completing a report on the co-location initiative, and looking into further joint working initiatives such as development of cultural assessment tools.

In terms of advice, innovators need to be both patient and persistent. Immediate follow-up and action is necessary for progression to occur successfully. Establishing relationships and effective communication processes are also vital.

## **Scope of Practice for Primary Care Key Workers**

***Anne Marinelli-Poole, Organisational Learning and Development Manager***

CMDHB acknowledges the importance of the Community Health Worker (CHW) workforce and appreciates the value of developing CHWs to be able to deal with:

- The growing population of the region, many of whom are suffering from a chronic condition (s).
- The presence of health inequalities particularly in Maaori, Pacific, Asian and refugee communities.
- Increasing cultural diversity within the region which needs to be represented in the workforce.

To date CHWs have been an unregulated workforce without professional structure, qualifications, a career pathway, and standards of practice. However, they are increasingly being relied on to work in partnership with traditional health professionals to provide health care in clinics and in people's homes, workplaces, and communities. The absence of a scope of practice and associated competencies results in safe practice risks, which creates potential risks to patients as well as the CHWs themselves.

The Scope of Practice for Primary Care Key Workers (PCKW) project aims to articulate and strengthen the current and future role of CHWs working in the Counties Manukau district in order to:

- Ensure patient and health practitioner safety;
- Define and strengthen the role of CHWs as a bridge between primary and secondary care services and individuals, whaanau and communities;
- Introduce standards to govern patient management processes and systems;
- Identify and inform the standard of job content, supervision, coaching and mentoring required for the CHW role;
- Identify formative and ongoing training requirements, a clear career pathway and competency framework; and
- Provide support and mentoring for managers of CHWs.

The project has been driven by a number of factors, including the changing health care environment with delivering 'Better, Sooner, More Convenient' health care services. Models of care are changing and with that come changes in workforce requirements. The safety risks and a lack of core competencies and clear career framework are also important drivers. This project is being developed by Primary Care, Learning and Development and Workforce Development.

From May 2008 to March 2009 an extensive stocktake and consultation process was undertaken to identify the size, composition, current skills and range of roles of the Counties Manukau CHW workforce. Following the stocktake, a business case was prepared proposing a project whereby the DHB would work in collaboration with Primary Health Organisations (PHOs) and Primary Care Providers, to design, test, evaluate and

amend a Scope of Practice for Primary Care Community Health Workers<sup>4,5</sup>. Funding was approved and in late 2009 CMDHB commissioned Solutions Ltd to develop, pilot and amend a Scope of Practice for CHWs in primary care and develop a competency framework for those CHWs.

There were several barriers to overcome, especially at the beginning. These generally involved a lack of interest and/or prioritisation issues. However once the value of this project was realised, getting people on board was not an issue.

CHW training is currently available through MIT (programme was developed specifically for CMDHB). While considered to be a very good programme, there are some gaps, particularly in delivery. Work-readiness is the issue most commonly cited. MIT and Careerforce are both keen to work with CMDHB on this project and both will be engaged going forward in order to design a step-on/off qualification aligned to the scope of practice/key competencies. We will also be seeking a programme which has a significant work-based training component as part of the delivery.

Funding has been sourced from various workforce development budgets, and a comprehensive evaluation (conducted by UniServices) is running alongside this project. The draft scope is currently being developed along with key competencies; these will be piloted over a one year period. New training models will be developed. This project also offers opportunities related to 'Growing our own', to 'Better, Sooner, More Convenient' health care plans and to the overall development of this workforce.

Cooperation of the parties involved has been critical to success thus far, as well as perseverance. Barriers don't need to be accepted – they can be overcome.

---

<sup>4</sup> Counties Manukau District Health Board: Business Case for Safety to Practice. A Scope of Practice for 'Primary Care Key Workers'. 31 March 2009.

<sup>5</sup> Counties Manukau District Health Board: Business Case for Safety to Practice. A Scope of Practice for 'Primary Care Key Workers'. 31 March 2009. (A3 summary)

## **Acting Up into Different Positions, ARHOP**

***Dana Ralph-Smith, Service Manager, Acute Allied Health, AT&R Unit, Pukekohe and Franklin Hospitals***

One of the most innovative ways to develop staff working in ARHOP (Adult Rehabilitation and Health of Older People) has been through creating opportunities for staff to act up into more senior positions. A ward Associate Charge Nurse Manager (ACNM) acted up into the role of Charge Nurse Manager (CNM) for a 6 month period while the Charge Nurse Manager was seconded to a project role.

AT&R (Assessment, Treatment and Rehabilitation) has been reviewing and upgrading their models of care in preparation for their ward moves to AMC and the opening of new Health of Older People (HOP) beds. At the time Ward 23 was providing an under-65 neurological rehabilitation service and a HOP service in the same ward with very different systems and processes. The Charge Nurse Manager of Ward 23 was seconded to a project to combine these services into one adult rehabilitation service. This gave the ACNM an opportunity to act up in the role of CNM for six months.

The AT&R managers and Ward 23 staff were the main staff involved in implementing the innovation. All three AT&R wards currently have ACNMs who step in to support their wards if the CNM is on leave, but they do not undertake the whole role during these times. This innovation gave the ACNM in Ward 23 an opportunity to take on all aspects of the CNM role but with the current CMN still available for support. This gave the ACNM an opportunity to try on the role and see if this was a future career step for them.

There were no significant challenges, mainly as the ACNM had been in their role for awhile and was ready for this growth opportunity. The only training required related to the areas of budget management and staff management, and this was primarily provided by the AT&R Operations Manager. In terms of funding the innovation management agreement was required to access funds to pay the additional “acting up” costs whilst the CNM took on the project role. This was offset by staff vacancy dollars that were available at the time.

The CNM has since resigned to take up a position of CND. The ACNM during this innovation is now the CNM. She was interviewed against other candidates for this role and her acting up period had given her an advantage during the recruitment process. In the CNM role she has required less training and support than if a completely new candidate had been successful. She was also well aware of what the role entailed before she took it on.

In terms of advice to others considering a similar innovation, every opportunity that exists to give staff a chance to act up in a role should be taken. It is the foundation for “growing our own” and informs managers of what employees are capable of. It allows staff to try different/new roles before they are committed to them. It reduces orientation time if a new person in a role has done it before. Finally, it gives employees an appreciation of what their managers really do.

## **Surgical Services: Workforce Development in Action**

***Kathy Wright, Clinical Nurse Director Surgery, Ambulatory Care and Women's Health***

Surgical Services has undertaken several workforce development initiatives in recent times.

### *Workforce Development Coordinator*

A nursing Workforce Development Coordinator role has been introduced. The Coordinator manages all CVs coming into the service, organises the recruitment process (including interviews), and supports the Clinical Nurse Managers (CNMs). The role was instigated as CVs were taking too long to process, hence potential staff were being lost. This role has supported Surgical Services to go from a deficit of 100 nurses (January 2009) to just 8 at January 2010. The Coordinator also provides a pastoral care role for new staff, including CNMs (retention benefits) and does exit interviews for staff leaving.

### *Nurse-Led Clinics*

Within the modules at MSC Nurse-Led clinics have been introduced. This is a new way of care delivery that impacts positively on both the patient journey as well as clinic throughput. There is one clinic already operating - the Wound Care clinic - and several in the pipeline (Urology, Ophthalmology, ORL, Pre-admission and Burns).

### *Theatre Admission and Discharge Unit (TADU)*

The new Theatre Admission and Discharge Unit (TADU) replaces the old DOSA which saw patients (particularly Plastic / Hands / Orthopaedics/ Gynaecology) returning day after day and waiting hours to potentially get a slot on a theatre list.

TADU now provides a planned appointment system (acute-arranged) in a new purpose built area across the corridor from theatre. New injuries can be sent up from ED, reviewed by a registrar between theatre cases and a decision made as to whether they require surgery or not. If they do they get an appointment to come back, and if not their injury is dressed and they are brought back to the Nurse-Led clinic at MSC (or a Registrar clinic if that is appropriate).

The second function of the Unit is to "pull" patients from EC who would normally be admitted (e.g abscess for incision and drainage). TADU staff will prepare the patient for theatre and recover them afterwards (once awake from the main recovery area). As they have extended hours, they are able to keep the patients until they are ready for discharge. This supports not only the 6-Hour target by pulling these patients, but prevents a bed being used by someone who would just be discharged in the morning anyway.