Wanaka Medical Centre

Interview with Leigh Cashen– Practice Nurse

Summary

This case study describes a change initiative driven by a practice nurse with post graduate training and education in long terms conditions and self-management support, to shift a practice from an ad hoc to systematic approach to delivering services to patients with LTCs.

Background

Wanaka Medical Centre is part of WellSouth PHO and the Southern District Health Board. Practice Nurse Leigh Cashen is a member of the Southern Leadership Alliance Team for Long Term Conditions LTC). This team is developing policy, guidelines and practical tools and training for all of the organisations within the Southern Leadership Alliance.

Wanaka Medical Centre is a rural general practice providing medical care including accident and emergency services, to the Wanaka Community. There are nine GPs and nine practice nurses in the practice and most work part time.

As a result of completing a LTC post grad paper 5 years ago, Leigh identified that change was necessary to deliver better services to their enrolled population. First Leigh got the support of the GP Partners. to set up systems to support people with LTC and review the practice's used of Care Plus funds.

Leigh developed a detailed action plan describing the purpose of the programme, the roles of the GPs and nurses, training needs, resources (including IT), barriers and mitigating factors. A long term conditions management policy was developed including a pathway and three levels of service provision. Implementation of the three levels has been slow and currently everyone on the LTC programme gets the same service. i.e. 2hours of nurse visits/yr. The proposed Southern Alliance Team recommendations will change this.

The programme

The practice has moved from a fairly ad hoc to a more systematic arrangement. Now LTC consults funded by the Care Plus money are nurse led. Every patient on the LTC programme has a funded 30 minute appointment with the nurse every 3 months. GPs are be guided by nurses on repeat scripts for example and the nurses can arrange for a GP appointment if needed. Main benefits are better use of patient time because they don't have to see GP for repeat scripts etc. every 3 months. In addition GPs have additional time to see people needing acute care. However some GPs do like to see their patients every 3 months regardless.

The Flinders Partners In Health (PIH) tool is used to inform the care plan which was developed by the practice. All documents are available as outbox documents in Medtec. Patients are given hard copy of their care plan.

The practice uses Manage My Health and the patient can't yet view their care plan or their notes through the patient portal. Currently patients are given a printed hard copy of their care plan.

Part of the process included the development of a culture of continuous improvement within the practice and many systems have been developed and amended as the result of PDSAs and ongoing reviews. All policies and procedures are reviewed annually for Cornerstone accreditation and at the monthly LTC team meetings things are changed and new ideas tested particularly when something doesn't seem to be working.

Challenges

- Medtec doesn't flag to the GPs when changes have been made to the care plan so GPs don't often look at the plan. The plan can't be shared with care providers outside the practice
- Getting all of the nurses (5 mostly part time) to the same level of knowledge and understanding about LTC. Leigh is the only nurse to have completed Flinders training and the LTC papers, she has also completed the post graduate paper in diabetes nursing. One nurse specialises in respiratory and one has a background in cardiac rehabilitation. Two nurses, have been trained in advanced care planning. WellSouth provides good study days and supports ongoing professional development However LTC and self management training is difficult to access.
- Nurses perceive that there is a lot of paperwork associated with the LTC process because nurses have to complete a screening tool, the Flinders Partners In Health scale and then develop a care plan. This perception is slowly changing now nurses are more familiar with the tools and all LTC documents are available on nurses' desktops.
- Lack of integration with secondary services creates a number of issues both for the practice team and for patients. The diabetes specialists only communicate with the diabetes nurse specialist based at Dunstan Hospital. Maternity and paediatric diabetes patients receive their care from secondary services based in Dunedin. This creates a number of continuity issues particularly given the travel time and distances involved.
- Insufficient admin time initially..However changes were made to nurse and receptionist tasks and time and now one of the receptionists attends the LTC team meetings.
- Mindset shift for nurses from having to 'fix' all of the patients problems to new mind set of supporting the patient to fix their own problems. This is still a problem compounded by the lack of other support/clinical services available in the locality e.g. funded podiatry, eye screening, respite services (at least one hour away or in Dunedin which is four hours away).