EXEMPLAR DOCUMENT

National Group
of
Professional Development Co-ordinators
for Practice Nurses

April 2009
Introduction

This exemplar document gives an insight into some of the projects the Professional Development Co-ordinators for Practice Nursing have been involved in, over the past six years. It demonstrates the enthusiasm and progressive thinking within the group and their support and understanding of the Primary Care Strategy (2001) and the implementation of The Transformation Programme (HSE, 2007-2010).

These projects demonstrate both practice and professional development initiatives which will assist in improving and developing services and therefore patient outcomes. This will ultimately have impact on the patient journey/care pathway, as outlined in the HSE Transformation Programme.

The Professional Development Co-ordinators for Practice Nurses (PDC’s) are based within the HSE administrative areas and have responsibility for the strategic development of Practice Nursing within General Practice. Their aim is to collaborate with all key stakeholders to plan and develop a quality driven nursing service across primary care in line with national and corporate health strategies.

Implicit within this role is practice development, which supports general practice to optimise client outcomes. Facilitation of the adoption of evidence based practices in nursing care and service delivery within primary care is encouraged and this is achieved through commissioning, co-ordinating, developing and delivering training and development initiatives that strengthen the professional expertise of Practice Nurses and their integration within the wider community nursing and primary care teams.

PDCs also facilitate new specialist (Clinical Nurse Specialists in General Practice) and advanced (Advanced Nurse Practitioner (Primary Care) nursing posts within this sector which will assist in improving service capacity and aid individual practices and primary care teams to achieve their objectives.
The role of the Professional Development Co-ordinator for Practice Nurses is therefore a facilitative and collaborative one, having regard to the independent contractor status of general practitioners (GP) and the GP’s position as the employer of the nurse.

The Professional Development Co-ordinators for Practice Nurses’ nationally promote the expertise and contribution of Practice Nurses within Primary Care.
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Introduction to Practice Nursing Course

“All nurses practicing in the community should be provided with an appropriate in-service training and orientation”

(Ainna Fawcett-Hennessy, 1996)

Increasing demands for efficient, appropriate and effective primary health care, changes in health policy and the ways in which community health services are delivered have contributed to the escalation in the number of practice nurses. Presently there are approximately 1,400 nurses employed within Irish general practice. As yet there is no mandatory educational programme or qualification available to nurses who wish to become practice nurses. A needs analysis, including an examination of the training profile of employed practice nurses, undertaken by the Professional Development Coordinators (PDC’s) for Practice Nurses in the HSE Dublin Mid-Leinster Wicklow & Kildare and Dublin North areas, reveals a highly traditional nurse training, RGN (Registered General Nurse) with or without midwifery- for a new and expanding area of nursing. The paradox of namely a predominantly hospital based training for a predominantly community based job. Our subsequent contact with many practice nurses, confirms a demand for the type of course suggested by Fawcett-Hennessy. This particular course has been designed to assist nurses in their transition from secondary care to primary care and should not to be seen as a definitive ‘vocational training’ model.

Moving from hospital-based nursing to working in the general practice/community can be particularly difficult. This course offers the participants not only an orientation into General Practice/Primary Care but educational, professional developmental and clinical/practical support in their new practice arena. The curriculum addresses a variety of areas all relevant to practice nursing. The presentations are given by ANPs, CNSs, and doctors with specialist knowledge in their subject, the PDCs and not forgetting the participants themselves who are required, on the last day of the course, to deliver to their peers a six minute talk on a subject of their own choice relating to nursing. The course has the approval of An Bord Altranais and is supported by a grant from the National Council for the Professional Development of Nurses and Midwives. The course runs over a period of eight weeks on one day per week. The timing allows for the reflection on, and the assimilation of new knowledge or a new perspective i.e. Primary Care.

Comments of students who have completed the course;
“Enjoyed the course immensely … has given me an excellent knowledge base starting off on my career as a practice nurse, it was a fabulous course!”
Another participant commented
“Broad range of topics which were very interesting” showed “the right way to set up your practice”.
When asked if the course would encourage further structured professional development, one student stated that
“Hope to do the Higher Diploma in a couple of years’
Whilst a number said they would plan to undertake “Individual modules in Asthma and Diabetes”.
When asked how the course would impact on their practice? Answers such as
“a great source of information” “made me aware of all I learned in 8 weeks and gave me more confidence” “evidence base knowledge will help to keep me safe in practice”.
The course has been run four times and approximately seventy eight nurses have completed the programme. Presently a waiting list exists emphasising the need for such a programme. Using local resources this course is being offered by a number of the Professional Development Co-ordinators for Practice Nurses in various areas of the Health Service Executive, thus enabling all practice nurses to have a structured introduction to their career in Primary Care/Practice Nursing

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Postgraduate Diploma in Nursing (Practice Nursing and Community Nursing) NUIG Galway

Professional Development Co-ordinators for Practice Nurses collaborated with the Department of Nursing Studies at NUIG in the development of a Postgraduate Diploma in Practice Nursing and Community Nursing. This programme, developed within the context of the National Framework of Qualifications at level 9, endeavours to provide a sound theoretical and clinical basis for nursing in the primary care and community setting and equip registered nurses to work collaboratively with general practitioners and other health professionals in promoting the health and wellbeing of individuals, families and the community. The curriculum is delivered collaboratively between the National University of Ireland Galway School of Nursing and Midwifery, the Department of General Practice NUIG, and the Health Service Executive. The programme reflects the Department of Health and Children's (2001) agenda and the Transformation Programme agenda in supporting the delivery of quality best practice care and contributes to the creation of an environment which is willing to embrace a new model of integrated care delivery: Primary Care Team development.

The programme, commenced in 2006 as a Practice Nursing Postgraduate Diploma, was reviewed and renamed in 2008 with applications open to nurses in primary care, community care, out of hour’s services and prison nurses. The review committee members’ varied and wide-ranging experience ensured that all aspects of Practice Nursing and Community Nursing were considered as the curriculum was developed. The programme received accredited by An Bord Altranais for 5 years until 2013 and can be undertaken on a full time basis and completed in one year or part-time over two years.

The programme is comprised of seven theory/Practice Nursing/Community Nursing modules. Module content is viewed as interconnected and interdependent. In all modules there is an emphasis on exploring the relevance of module content to Practice
Nursing/Community Nursing. While undertaking the programme students continue to work in a General Practice/Community Nursing setting. Practice Nursing/Community Nursing assignments are structured so as to allow students to explore new knowledge in the reality of their Practice Nursing/Community Nursing, thus providing them with an opportunity to integrate theory and Practice Nursing/Community Nursing.

The programme is offered within a blended learning format, utilising Blackboard: a Virtual Learning Environment that supports online learning and teaching which can be accessed by registered users off campus using the internet and web browsers. This blended learning format is vital as it provides an opportunity for nurses throughout the country who would not have been in a position to travel to NUI Galway on a weekly basis to undertake this programme.

Funding for this programme has been negotiated by Practice Nurses PDCs and agreed annually to date with Primary Care Managers in each area.

All Practice Nurses / Professional Development Co-ordinators are Course Committee members and act as preceptor to the Practice Nurses undertaking this level 9 programme. This involves clinical assessment visits and use of a tailored Benner’s competency assessment tool. A clinical site visit takes place at the beginning of each programme. The aim of the clinical site visit is to make available resources which might be useful in promoting student interest and engagement, and promote the development of practitioners who will continue to learn about and use research throughout their clinical careers. Each clinical site receives a clinical resource pack and contact details for key personnel involved in the programme. The site visit also aims to acknowledge the central role clinical based practitioners add to students learning. Practice Nurses PDCs attend a meeting with the External Assessor at the end of each academic year.

This Postgraduate Diploma supports the attainment of Clinical Nurse Specialist status awarded by the National Council for Nursing and Midwifery. To date seven Practice Nurses have made successful CNS applications following commencement and completion of this programme.

An evaluation of the graduates of this programme was undertaken in 2008 to determine how the programme has influenced clinical practice and patient care and what practice
initiatives that impact on patient care have been implemented by these Practice Nurses, the findings of which are available upon request.

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Advanced and Specialist Nursing (Primary Care) Research Study:  
An Exploration of Professional and Organisational Issues in Ireland

Professional Development Co-ordinators for Practice Nurses are responsible for the development of the skills, knowledge and effectiveness of Practice Nurses and facilitate the establishment of specialist and advanced nursing roles to meet patient need, with over 10% of all clinical nurse specialist posts from primary care (Oct 2008).

This research study which was undertaken in July 2007, explored the organisational and professional issues affecting Advanced Nurse Practitioners (Primary Care) and Clinical Nurse Specialists (General Practice) within the Republic of Ireland and considers the implications for management, education and clinical practice.

The data collection method chosen was semi-structured interview with analysis undertaken using a qualitative thematic approach. The sample was obtained from the data base of accredited Advanced Nurse Practitioners (Primary Care) and Clinical Nurse Specialists (General Practice) held by The National Council for the Professional Development of Nursing and Midwifery.

The phenomenological approach adopted explored the “lived experiences” of ANP and CNS within the primary care sector and following data analysis, major organisational and professional issues were identified.

Major organisational themes identified included;  
- the importance of supportive professional relationships within primary care,
- nursing aspects and influence on service development and  
- enabling factors and barriers affecting advanced and specialist practice.

Major professional themes identified include;  
- role development for advanced and specialist practice,
Findings indicated that organisational and professional issues are interlinked and suggested that advanced and specialist nurses possess intuitive organisational knowledge and utilise their social network and professional value systems to maximise patient and service outcomes within primary care. The study identified issues relating to workload pressures, professional isolation and educational deficits that inhibit development of clinical career pathways for advanced and specialist nurses within this sector.

The commonality and divergent themes between CNS (General Practice) and ANP (Primary Care) were identified.

- Issues relating to attainment of core clinical and professional competencies due to workload pressures and lack of time.
- Continuing education requirements indicated that ANP required clinical updates at advanced practice level, with CNS requiring access to specialist Higher Diplomas and education that accredits prior learning.
- Both cohorts identified a need for professional peer support frameworks; CNS required a Professional and Service Development forum and ANP a Practice Development Forum.
- Divergent themes centered on ongoing role development, for ANPs the ongoing need to promote the role and CNSs requested further development of negotiation skills.

Policy makers, managers, clinicians and educationalists can further enable effective fulfilment of advanced and specialists nursing practice roles through recognising the unique personal and professional skills set required to work within this sector and addressing the deficits that have been identified within this study.

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A New Initiative to Support Chronic Illness Management

Cardiovascular Management for Nurses

It is estimated that eighty per cent of General Practitioner consultations relate to chronic disease. The prevalence of ischemic heart disease is approximately 12% in Ireland. Based on their professional experience a Practice Nurse Needs Assessment Study in the Dublin Region in 2004 identified a need for further education in the area of chronic disease management (Forsythe, Williams and Lawlor, 2004).

Subsequent to this study Rhonda Forsythe and Marian Wyer proposed the development of Chronic Disease Management modules in partnership with representatives from their local Centres for Nurse Education (CNE), in Tullamore and Connolly Hospital. A steering committee was formed comprising of a Heart Watch Facilitator, a Practice Nurse, a Public Health Nurse, a Nurse Tutor with a specific interest in Cardiac Care and CNE representatives. A GP representative was invited onto the group but was unable to attend. Funding was accessed and a project officer was identified and commissioned, through funding from the NMPDU in Tullamore and Primary Care Unit in Dublin North. After considerable research Dublin City University was chosen as a partner and the accrediting body for the programme. The steering group then proceeded to develop the module entitled.

Title: *Cardio Vascular Management for Nurses in Primary Care*

This module is accredited at level 8 of the National Qualification Framework. It carries an academic currency of 5 credits as a stand alone module and a specialist module on the BNS Community programme. It can be used as a potential access module onto post graduate programmes in DCU.
This programme was piloted through both CNE in 2007. The candidates consisted of nurses from Community, Public Health and Practice Nursing. It was very well received. Due to demand the module was broadened and opened to all disciplines of nursing, and is now entitled:

**Cardiovascular Management for Nurses.**

This module encourages nurses to critically examine the care they deliver and assist them in developing a patient centred approach to care.

One practice nurse remarked “I have started a cardiac clinic in my practice. Anyone who has cardiac problems is referred to me for review, i.e. Secondary prevention. Those with multiple risk factors e.g. family history, high blood pressure, cholesterol etc. are referred for primary prevention. I do half an hour consultation discussing their risk factors, full blood check, height, weight, BMI etc., blood pressure, ECG and discuss diet.”

Another practice nurses commented, “I have a greater understanding of risk factors and the link with cardiovascular disease. I do more random blood pressures; ask re lifestyle and risk factors. As a result I do a bit of opportunistic health promotion”.

Nurses have a significant role to play in the management of chronic disease. This module assists chronic illness management to be achieved more efficiently especially in the Primary Care setting. It empowers the patient and recognises the importance of good communication thus enhancing integration of care across disciplines in line with stated health policies. *(Tackling Chronic Disease; a Policy Framework for the Management of Chronic Disease. DoH&C)* (A National Chronic Disease Management Patient Support Programme for the HSE, Report of the National Steering Committee 2006.)

To conclude this development and approach can be viewed as clearly supporting priorities within the HSE Transformation Programme and improving patient care.

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Due to the positive evaluations of the Cardiovascular module and being cognisant of the relationship with cardiovascular and diabetes management, the steering group decided to develop further modules addressing the areas of

- Diabetes Management
- Respiratory Care Management
- Care of an individual with Long Term Illness, (not disease specific).

Research indicates that there is an anticipated increase in the prevalence of diabetes over the coming decades and that already as a country Ireland has a growing prevalence of respiratory related illness especially in the areas of asthma and COPD.

The same development framework as used in the cardiovascular module was adapted by the steering group in relation to these additional modules along with considerable input from Clinical Nurse Specialist (CNS) both in the Community and Secondary care settings, in their respective specialist area. These modules were also accredited by DCU at level 8 of the National Qualification Framework and carry the same academic standing, as the cardiovascular module.

The Diabetes module entitled-

*The nursing management of persons with diabetes*
It was highly evaluated, a practice nurse stated, “This programme has given me the incentive to change how we give care in the practice. I have presented some new initiatives to the GP and he is impressed and has encouraged me to implement them.”

Another practice nurse commented, “I found the diabetes module invaluable to my patient care. Since then I carry out HbA1C bloods every 3 – 6 months depending on the patients. I also feel I know a little bit more about insulin and drugs regimes”.

The Respiratory module entitled-

**The Nursing Management of Persons with Respiratory Disorders**

Has recently run in both Dublin and Tullamore CNEs and it too was very successful. One practice nurse participant stated through her encouragement “Our practice has invested in a spirometer machine and I feel very competent in using it”.

All these Modules are available nationally through DCU and Centres of Nurse Education, thus enabling nurses to have access to professional development and evidenced based education.

Finally a practice nurse remarked on the modules, “All in all I think they are very worthwhile in doing. You meet nurses from other areas, it is great to get a different opinion and by the end of the module you have made links with community and hospital which is important in achieving best practice for our patients.”

These modules assist the nurse in keeping the patient central in the care process and support some of the priorities stated in the Transformation Programme.

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Initiating a Pulmonary Outreach Programme in a Rural Environment – Longford/Westmeath

Chronic Obstructive Pulmonary Disease (COPD) is a chronic disease state that is characterised by airflow limitation that is not fully reversible. (GOLD 2003) COPD is associated with acute exacerbations and there is a correlation between frequency of exacerbations and accelerated decline in lung function. In Ireland the average length of hospital stay is 8.6 days (Murphy, 2003). The HSE, midland area, identify similar figures. Primary and secondary services need an integrated approach to treating this disease. Having completed a Post Grad Diploma in Nursing (respiratory) the Midland PDC initiated this project to bridge the gap in care.

International and National evidence shows that COPD patients can be effectively and efficiently managed at home with greater patient and carer satisfaction. (Swarska, 2000). The National Health Strategy - A Health System for you (2001) states that "appropriate care should be delivered in the appropriate setting & that individuals and families will be supported and encouraged to be involved in the management of their own care" (DoH&C, 2001).

An Outreach Programme is defined as “A service that provides active treatment for a limited time period in a patient's home of a condition that otherwise would require hospital in-patient care” (Shepperd and Lliffe, 1998).

The objectives of the Programme are:

- To reduce hospital inpatient stays
- To support and assist in the development of integrated care pathway structures with the Acute and Primary Care sectors;
- To reduce morbidity caused by chronic respiratory conditions affording patients and carers an opportunity to remain in the workforce, thus reducing the national burden of disease.
• To develop best practice initiatives in how care for chronic respiratory disease could be structured and provided in a person centred manner e.g. LTOT structured assessment process.
• To review the current services of Respiratory CNS post and explore the use of specialist nursing roles, in the community setting in response to service need
• To address the continual professional development of all nurses, working within the multi-disciplinary team, thus building on clinical competencies and expertise.
• To explore the concept of self management plans to strengthen and support the patient’s own capacity for self care. This should lead to a reduction in patients suffering acute exacerbations of their chronic illness and subsequent admissions to acute hospitals, in keeping with national policy.
• To promote the early discharge of patients to a supported environment;
• To ensure that while service delivery is developed and maintained the patient is kept central in all developments addressing chronic respiratory disease management;
• To enable patients with chronic respiratory disease to have a voice in the planning and delivery of services.

**Patient outcomes for pilot year March ’06-March ‘07:**
Early discharge programme (29 participants) - median length of stay was 2days
Assisted discharge programme (52 participants) – median length of stay was 6days
A number of outcomes were measured to determine patient perception of breathlessness (BORG and MRC score) and Quality of Life score (EuroQol and Health status). On day 14 of the programme all patients showed improvements in their perception of breathlessness and their quality of life status.

The Pulmonary Outreach Programme is offering patients options in their care delivery. It is making a significant impact on patient’s lives and is bridging gaps between Primary and Secondary care. It offers a model for the prevention and management of chronic illness in keeping with the HSE Transformation Programme 2007-2010. Marian Wyer initiated the programme and worked (.5 WTE) as project lead, with a senior physiotherapist, for the first twelve months. Following a positive evaluation she handed the project over to a CNS and physiotherapist. A funding application was submitted on behalf of the stakeholders to the National Council for the professional development of
Nursing and Midwifery Grant Funding – Chronic Disease Management ’08. Funding was granted to expand the programme. Marian will have a role in planning the project & doing six monthly reports to the NCNM.

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A Diabetes Management Conference held in Cork in September 2008 was the impetus for Dr. Quinlan from Glanmire Medical Centre in Cork to present a poster demonstrating the results of an audit of diabetes management of the population in this Cork suburban practice. Professional Development Co-ordinator for Practice Nurses, Marie Courtney was a member of the Active Management of Diabetes in Primary Care Conference Committee and encouraged Dr Quinlan to complete this piece of research to embed the clinical learning developed at the conference.

The research is very relevant as the emphasis was particularly on the detection & diagnosis of Pre-diabetes & type II Diabetes Mellitus and explored the role of patient age in diagnosis. The study clearly showed that using an oral Glucose Tolerance Test in patients over 50 years of age identified that 34% of GTT’s were abnormal.

“Diabetes is a major public health issue which can be effectively managed in primary care and that a team based approach including all members was an essential element of the successful audit and implementing the findings did not generate an onerous additional workload”, stated Dr Quinlan.

“Practice has changed as a result of the Diabetes conference and the subsequent learning gained” with an expanded use of GTTs’ among patients over 50 years of age,
while reducing the number of GTTs’ in younger patients. The practice holds regular team meetings which provides a forum for discussion of ongoing quality initiatives, team members are encouraged to actively participate and as such quality improvement is built in to routine practice activity.

There is no doubt that this targeted approach has had a positive impact through early detection of pre-diabetes and focused monitoring of the at risk practice population. The policy framework entitled “Tackling Chronic disease” stated that there is good international evidence that many patients are receiving sub optimal care due to inadequate identification, incomplete diagnostic registry, lack of application of evidence based guidelines and poor patient compliance (DOHC (2006).

Working in collaboration with GPs from the Diabetes Interest Group, the Diabetes Nurse Facilitator (at UCC) and the Heartwatch Facilitator (HSE South) in building a conference programme that would have a real impact on primary care practice and appeal to Doctors, Practice Nurses, Public Health Nurses, Podiatry, Dieticians and others. Over 100 from the primary care sector attended the conference, which was hosted at UCC and Professional Development Co-ordinator (Practice Nursing) (PDC) in Cork and Kerry, Marie Courtney stated that the underlying ethos of the Conference was “to promote a team based approach focusing on treating to (best practice) targets and enhancing service user involvement in their care through raising clinicians awareness of factors affecting patient motivation”.

This conference and its subsequent outcomes are in keeping with the HSE Transformation Programme 2007-2010.

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HSE West Diabetes Resource Manual

The PDC for Practice Nursing in HSE West (Limerick Clare & North Tipperary) established a multidisciplinary Diabetes Steering group in 2006 to enable an integrated approach to the delivery of diabetes services in the region.

Background Information
The aim of this initiative was to compile a Diabetes Resource Manual providing up-to-date and evidence-based information for all health professionals involved in the management of diabetes mellitus across the HSE West.

This initiative involved extensive collaboration and close working across traditional geographic and health service boundaries. The Diabetes Resource Manual Taskforce comprised both primary care and hospital-based health professionals from the three areas within the HSE West Region. Taskforce members were united in their enthusiasm, commitment to change and vision for an integrated diabetes service.

The initiative centres around the new HSE Model of Care, which increases emphasis on primary care-based management of stable chronic diseases, and is in line with Programmes 1 and 4 of the HSE Transformation Programme 2007-2010. The Diabetes Resource Manual addresses this problem by including a Guide to Local Diabetes Services for each county. Contact details and information on accessing services such as community dietetic services, chiropody services, retinal screening services and hospital based clinics are supplied, thereby ensuring that care can be provided in the right place, at the right time.

Methods Used
A Taskforce was formed in October 2005, comprising Consultant Endocrinologists, Advanced Nurse Practitioners, Diabetes Nurse Specialists, General Practitioners, Primary Care, Public Health and NMPDU representatives from across the HSE West Region. Information for the Manual was sourced from many healthcare professionals involved in primary and secondary care to ensure that it reflected local practice needs. A comprehensive consultation process was undertaken. In May 2007 the 150 page Manual
was printed and in June 2007 official launches took place in the HSE West, HSE Midwest and HSE Northwest Areas. The Resource Manual is now being distributed to all GPs, Practice Nurses, Health Centres, Community Pharmacists, Community Nursing Units and Hospitals in the Region. The next phase of the initiative will be the development of Guidelines for Inpatient Care, which is planned for Autumn 2007.

Evaluation/Outcomes Measured

In June 2007, before the launch of the Manual, a Survey of the Provision of Diabetes Services in Galway City & County was carried out in collaboration with the Department of Population Health, HSE West. Comparison of this baseline information on the quality of existing diabetes care, with a follow-up survey in June 2008, will help demonstrate any improvements in diabetes services and care in the County ensuing from the launch of the Diabetes Resource Manual. In 2004 in Limerick, Clare and North Tipperary a needs analysis was conducted involving all Practice Nurses who identified Diabetes as the number one priority for education and resources available. Additionally a GP survey was conducted which confirmed this disease area as priority for further service development. The resource manual was launched in June 2007 and a follow up survey is due to be conducted early 2008 which will gather feedback from both GP’s and Practice Nurses measuring the impact of the resource manual.

The HSE West Diabetes Resource Manual Taskforce was the first joint diabetes initiative in the HSE West. Close working links were formed between the Taskforce members, resulting in the HSE West Retinal Screening Group being formed in January 2007 and a successful bid for funding through SPRI for Region-wide Development of the Diabetes Retinal Screening Service. In May 2007, these same links led the establishment of an overarching HSE West Diabetes Services Advisory Group to drive and oversee all future diabetes developments in the Region. Taskforce endeavoured to incorporate elements of each of these respective guidelines into the current manual. A formal evaluation of the effect of the Manual on the quality of diabetes care is planned for early 2008 on the quality of diabetes care is planned for early 2008.
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Warfarin Training Programme

Background
An ageing population coupled with the continuing expansion of clinical indications for anticoagulation therapy have increased the number of people requiring management on warfarin therapy. This sustained increase means that different models of care are required. In his opening address in the Transformation Programme document, Professor Drumm’s refers to this evolving health care, stating: “change in the way health care is provided is not an option - it is a necessity” (Drumm, 2006). In a local study conducted by the Department of General Practice in NUI Galway, the need for standardisation of guidelines was highlighted as essential first steps for improving the effectiveness in primary care anticoagulation management (Daly et al, 2002).

Description
In 2007, under the auspices of the Primary Care Unit in Merlin Park, a Warfarin Working Group (WWG) was convened. This group included representation from stakeholders involved in warfarin services across the region. The development of a training programme that would support best-practice in the management of warfarin therapy was undertaken by core members within this group. The philosophy of the programme was to promote the delivery of a high quality, client-centered warfarin service, whilst offering continuity of care that would be geographically accessible to all who required the service.

In tandem with this programme, a comprehensive warfarin client information pack was developed for dissemination across primary and secondary care areas. A key objective in developing the packs was to promote the delivery of clear and consistent information for clients regarding warfarin, across the health care spectrum.

Outcomes
In October 2007, the first “Warfarin Training Programme” was delivered through the Centre of Nursing and Midwifery Education (CNME) in Castlebar. To date five programmes have been delivered in the region and a total of 83 participants (Table1) have completed the programme. This one and a half-day programme has been consistent in the positive evaluations received from participants.
In addition, through collaboration with NUIG Departments of General Practice & Nursing & Midwifery, the warfarin training programme is now accessible as a practical workshop element for all participants who choose the Cardiovascular Disease Module on the Primary Care & Community Nursing Post Graduate Programmes. The ongoing commitment will be to deliver at minimum, one programme on an annual basis for the region. Other regions who are interested in replicating the programme are being supported currently.

Table 1: Breakdown of participants who have attended the WTP in the region.

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<th>Area</th>
<th>Oct/Nov '07</th>
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Nurse-led Warfarin Management in Achill PCT

Identifying the need to support their knowledge and skills required in providing standardised, evidence based care to their clients on warfarin therapy, both Margaret O’Flynn and Marie Gallagher both Practice Nurses from the Achill PCT, attended the first Warfarin Training Programme (WTP). While they have always strived to provide best care to their clients they would say that since completing the WTP they have further expanded the service.

Margaret recalls a recent case of a client awaiting cardioversion.

“I liaised directly with the CCU staff in Galway University Hospital confirming that the INR was in range for the cardioversion and had been in the three weeks prior. Being able to facilitate in this way meant that our client did not have to travel the long journey to Galway for INR testing and there was reassurance that the procedure would be carried out as scheduled. The CCU staff were delighted to have this provided locally as deferring cardioversions because of INR’s being out of range is a particular nuisance for all concerned”

Here is a prime example of how expanded services in PCT’s facilitates in the effective utilisation of acute beds.

Achill’s PCT population includes a percentage of clients who are seasonal residents on Achill. A comment from one such client highlights the importance of a client centred services.

“I love being able to spend the Summer in Achill. We are very fortunate to have a fantastic service at the local GP practice here. Because I am on warfarin I need to have regular INR checks. I can call in to the Practice Nurse when I return and she will always accommodate me, this might have been a problem elsewhere. The service I receive in monitoring my warfarin have exceeded my expectations – It is a more efficient service than what I am used to at home”

In providing a comprehensive nurse-led INR clinic the overall burden for clients has been reduced. But more significantly the margin for error has been cut. When the process of monitoring individuals, adjusting warfarin therapy and prescribing are all done in one place the margin for error will automatically be reduced. Margaret and Marie are champions of client safety. Their contributions to the implementation of INR monitoring locally have been pivotal for the continued expansion in the management of warfarin
therapy for their clients. Their commitment to provide a more ‘person centred’ service that can provide continuity of care to individuals and their families is a shared objective for this Achill PCT team.

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Administration of Primary Immunisations in General Practice

"Immunisation is a simple, safe and effective way of protecting children against certain diseases. The risks from having these diseases are far greater than the risk of any minor side effects from immunisation."

National Immunisation Office

In 2008 the National Immunisation Office and the Department of Health & Children introduced a new primary vaccination schedule for babies and children under the age of two. This followed extensive work with the National Immunisation Advisory Committee. The Professional Development Co-ordinators for Practice Nurses (PDCs) attended the national conference in April with a view to rolling out training in their respective regions before the start date of September 1st 2008. All PDCs rolled out training in their respective areas and had a strong, influential leadership role in the support, education and training of PNs throughout the lead in to and the implementation of the new schedule.

In the five south east counties, the PDC is a member of the Regional Immunisation Team whose other members include Area Medical Officers, Senior PHNs, the Chief Medical Officer and administrative staff. This team as a joint effort rolled out ten educational sessions to PHNs and PNs around the counties. It was decided at a meeting to hold two half day sessions in each local health office to facilitate the extensive workload of community nurses and also to capture any nurses who may be working part-time or job sharing. Apart from travel expenses for the facilitators, the sessions were carried out on a cost neutral basis as HSE facilities were used. Over 120 PNs and over 100 PHNs attended the training in the south east. The sessions were very well valued by the nurses who attended.

The speakers at each session were the Area Medical Office, the PHN from the relevant area and the PDC for Practice Nurses. These educational sessions gave the nurses a chance to come together and learn about the new schedule and also to explore each others
role in the area of primary vaccinations. Topics included the reasons for immunisation, how vaccines work, consent, documentation and the administration of the vaccines. Comments and queries were explored and any matters raised were brought back for discussion at national level.

Ongoing support was available for the PNs through the PDCs as the schedule was rolled out and the PDCs continue to support the PNs with additional updates planned for 2009. The educational sessions contributed to the continuing professional development of both the PNs and the PHNs. This educational programme enabled the nurses to offer a quality holistic evidenced based care to their clients.

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The Professional Development Co-ordinators (Practice Nursing) have worked at a national level with the National Cancer Screening Service (NCSS) to support the coordination of smear taker training across the country in preparation of the national Cervical Screening Programme which commenced in September 2008.

Within the Cork and Kerry area in preparing for the national rollout, detailed negotiations with all stakeholders from the NCSS, Cork University Hospital laboratory and staff from the HSE. Marie Courtney PDC (Cork/Kerry) liaised with Carol McNamara and locally Niomh McCollam, Clinical Smear Taker Trainer and as a result, 158 Practice Nurses have attended the fully accredited Cervical Screening Course run via the Irish College of GPs (ICGP) and the Royal College of Surgeons in Dublin (RCSI), with 74 GPs and Practice Nurses attending an update course within 2008.

This training programme ensured the smooth rollout of the national cervical screening programme in September 2008. Nationally, 757 Practice Nurses have completed this course up to April 2009. (Appendix II)

Feedback from attendees was positive:

‘Excellent presentation from both presenters, very informative, relevant and precise’

‘Precise and to the point – covered everything’

‘Relevant and interesting presentations’

‘All very concise – no frills approach, very effective’

‘Presentations were excellent, yearly updates would be welcomed’

Marie Courtney, MSc, BSc (Hons), RGN.

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Midwifery Refresher Course for Practice Nurses/Midwives.

*Practice education is for practice and the best way to learn is to practise, but only when we have first learned some of the content (scientific) knowledge.*

P.Jarvis (1999)

The Maternity and Infant Scheme provides an agreed programme of care to all expectant mothers. This service is provided through a General Practitioner (GP) who has a contract with the Health Service Executive (HSE) to provide such a service and a hospital obstetrician, is usually referred to as ‘combined care’. This combined service entitles the pregnant woman to an initial examination, usually before 12 weeks and a further 6 examinations during the pregnancy, which are alternated with visits to the maternity unit/hospital. After the birth the GP will examine the baby at 2 weeks and both the mother and baby at 6 weeks. These visits are not liable for any charges.

Many GPs have in their employ within the practice, practice nurses registered with An Bord Altranais (ABA) as Registered General Nurse (RGN) as well as Registered Midwife (RM). Within the Mother and Infant Care Service agreement (presently under review) it appears that there is no permission allowing delegation of care, except to another physician. However, the delegation of ante-natal care and aspects of post-natal care is an acceptable delegation to a nurse/midwife. A practice nurse who intends to give maternity care within her practice is required under current legislation to notify each year the Health Service Executive of her intention to practice.

As Professional Development Co-ordinators (PDCs) for Practice Nurses, we recognised, through a needs analysis of practice nurses in the Greater Dublin Area, the lack of facilities for updating their theoretical knowledge and clinical skills in order to maintain their competencies within the maternity care arena.

The Centre for Midwifery Education at the Coombe Hospital Dublin agreed to develop a comprehensive two-day update course with us.

Aims of the course:

- To enhance the knowledge and skills of the midwife, who is working as a practice nurse
- To update the midwives knowledge and skills in relation to antenatal and postnatal care of the woman and her baby.
• To update the midwives knowledge in relation to the care of a woman in labour.
• To familiarise the participants to valuable midwifery and obstetrical/neonatal websites and other useful resources.

The course took place on four occasions over the summer of 2008. Clinical skills such as: examining the pregnant abdomen, postnatal examination of the mother and examination of the newborn took place in the ‘state of the art’ clinical laboratory in use at the Centre for Midwifery education. Theoretical presentations were given on Antenatal care, Common problems in pregnancy, Nutrition in pregnancy, Postnatal care, Community Midwifery service, Evidence on which to base Practice and Infant Feeding.

Formal evaluation by the course participants was extremely positive. Many commented “this course was exactly what we wanted” “I would have liked it to be longer”, however it is difficult for practice nurses to get time off for professional development and as this course was held on two consecutive days, their employers the GPs are to be congratulated for agreeing to their attendance. One PN put the overall opinion of the course participants succinctly when she stated “we now know that we as PN (RGN/RM) are giving excellent care to our mothers’ and their new babies”

The course was attended by 46 RGN/RM practice nurses in the greater Dublin area. A similar course has been held in the Southern area and is soon to be rolled out in the South Eastern area. We plan to run the course again this year in the Dublin area and in other locations nationally subject to demand.

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1 Health Act 1970, Department of Health and Children.
1 Section 57 Nurses Act, 1985 Department of Health and Children.
**Ear Care Programme**

Ear irrigation is a frequently performed procedure and is largely delegated to nurses in primary care settings. Research indicates that Nurses often have had no formal training in the safe management of ear care problems, and often the only training received is to observe another and then put into practice (Rodgers, 2000). The inappropriate use of equipment in assessing and treating ear care problems has significant risk management issues. It is important that Nurses are made aware of current best practice in this area.

Initially access to ear care training was an identified need within the Practice Nursing arena. This involved the Professional Development Co-ordinators (PDC’S) for Practice Nursing sourcing the training through two UK companies. 453 practice nurses in Ireland have been trained to date (Appendix II). Whilst these programmes were well received and evaluated positively overall, these arrangements are no longer sustainable or indeed suitable for current practice requirements.

The PDCs have established links with practice development colleagues from areas such as Older Persons Services, A&E, Intellectual Disabilities and Mental Health who have also identified a need to develop nursing services in ear care for their areas. Nurses working in these areas, by expanding their scope of practice to include ear care, contribute to services improvements for clients, in that services can be delivered in the most appropriate setting and within an acceptable timeframe. Access to ongoing education and training in ear care in an Irish context is required.

To this end, the PDCs have made formal arrangements with the Eye and Ear Hospital and personnel from that site are now working on a Train the Trainers programme for Ear Care which can be run through the CNMEs around the country. Several PDCs have successfully secured funding to purchase the necessary training equipment to enable this programme to be facilitated. With access to an established national ear care training programme, nurses working in clinical areas, who are interested in expanding their scope
of practice by providing nurse-led ear care services’, will have the necessary and appropriate professional support to progress this service development. Nurses trained in ear care reduce treatment costs, reduce the use of antibiotics, educate patients in ear care, increase patient satisfaction, and raise ear awareness. (Br J Gen Pract. 1997 Nov;47(424):699-703)

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Domestic Violence – A Guide for General Practice

Domestic Violence – A Guide for General Practice is the first national guideline that has been published in Ireland for general practitioners and practice nurses.

Domestic violence is a serious problem which is prevalent in our society. Irish statistics estimate that 1 in 5 women and 1 in 16 men will experience domestic violence within an intimate relationship at some stage of their lifetime (Watson and Parsons 2005). Domestic violence is not exclusively physical in its presentation but may also present as psychological, financial or sexual abuse. The complexities of domestic violence are multifaceted. General practitioners (GP’s) and practice nurses (PN’s) are health professionals that are readily accessible within our communities. However, due to the invisible nature of domestic violence its prevalence may go unnoticed by many health professionals for some time. Therefore a national guideline which assists GP’s and PN’s in recognising domestic violence, gives information on dealing with issues of abuse and information on how to make an appropriate referral will ensure a standardised approach to care.

The evidence based guideline was collaboratively developed with members of the Irish College of General Practitioners (ICGP), Women’s Health Development Officers (HSE), Planning Committee on Violence Against Women (HSE), Professional Development Coordinator for Practice Nurses (HSE), Women’s Aid and the Rape Crisis Network.

An evidence based tutors pack and a suite of educational material has also been developed by this multidisciplinary team to support training and education for GP’s and PN’s in managing issues of domestic violence in Primary Care. The training will be delivered to practice nurses nationally by the Professional Development Co Ordinator for
Practice Nurses (PDC) who have undertaken a “train the trainers” programme in preparation for the delivery. PDC’s play a vital role in co ordination and delivery of continuing professional development for practice nurses. A similar programme was also delivered to GP tutors who will disseminate the programme to GP’s. In some areas it is anticipated that this training will be delivered jointly to GP’s and PN’s by the GP tutors and the PDC’s.

This partnership approach to standardising care and the development of joint training and educational opportunities demonstrates team working between agencies in order to improve the outcome for those who experience domestic violence.

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Policy, Procedure and Guideline Development – Primary Care

In 2006 / 2007 Practice Nurses, Public Health Nurses and the primary care implementation site team members HSE West (Limerick, Clare and North Tipperary) identified the requirement for facilitation of Policies Procedures and Guideline Development. The training programme delivered constituted a valuable learning experience by enhancing knowledge of the development and production of protocols, policies and procedures and by providing the theoretical knowledge to underpin professional nursing practice.

The training facilitated Nurses in developing policies, procedures and guidelines and so promotes good clinical practice. The training programme is skills based, with a focus on developing staff competency in this area, to understand the importance of writing styles in developing documents, to gain practical skills in developing and implementing Policies, Procedures and Guidelines. PowerPoint presentations on overview of Policies, Procedures and Guidelines, Professional implications for practice, searching the literature and identifying best practice, identifying priority areas for policy development and develop and agree policy template. Presentation by participants of policy developed and maintaining and reviewing policies.

The training was provided by the Professional Development Co-ordinators for Practice Nurses who undertook, with PDC colleagues, a 5 day train the trainer programme on policy procedure and guideline development. Literature reviews, group work, feedback and discussion, peer reviews were some of the methods used.

Evaluation/ Outcomes measured

- Demonstrated knowledge of the similarities and differences between policies, procedures and guidelines and under-pinning theory in their development.
- Demonstrated knowledge of the professional implications for developing, maintaining and reviewing policies, procedures and guidelines.
- Demonstrated knowledge in identifying priority area for policy development.
- Displayed knowledge in obtaining and sourcing quality evidence to support best clinical practice.
• Developed draft policies, procedures and guidelines in the workshop and an action plan to address the ongoing policy development needs.
• Policies and guidelines have been developed, ratified and implemented in PCCC by working groups.

An evaluation of the impact of these documents is expected to be conducted in 2008. The guidelines are also being reviewed and updated as required. Further working groups are being formed to continue the process of developing policies guidelines and procedures.

To date, 181 Practice Nurses have been trained nationally (Appendix II)

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Medication Management Protocols for Use in a General Practice Setting

The currently existing practice for the delivery of the National Immunisation programme in primary care has been identified as needing review. The number of Practice Nurses in Ireland has increased in the past 10 years, with over 1450 nurses employed by GP’s in primary care. Nurses in primary care are ideally placed to meet and deliver the aims of both the HSE 2009 Service Plan and the Transformation programme priorities.

Practice Nurses in the general practice setting administer vaccines as per the nationally agreed schedule. In 2008 the HSE Immunisation Office (NIO) produced a comprehensive national immunisation training programme of education for health care professionals involved in immunisation. This training was organised and delivered locally to over 2,000 Practice Nurses, General Practitioners and Public Health Nurses. Attendance at the programme was voluntary. The importance of an individual prescription for each patient was recommended but no structural format to put this in place has been developed. Hence it remains a recommendation.

In 2007 approx 70,000 children were born in Ireland. These children receive their vaccines in primary care and the vast majority are given by a Practice Nurse. General Practitioners employ the skills of Practice Nurses to administer all aspects of the immunisation programme. This includes education of the parent around the vaccination programme, current schedule and obtaining consent for the administration of the vaccines. The delivery of the National Immunisations programmes is an important service need, and one of the priorities of the HSE 2009 Service Plan is to increase the uptake of childhood vaccinations. It meets all of the identified criteria for the development of a Medication Protocol.

In 2004 an examination of the concerns surrounding the practice of immunisation took place during focus group meetings between An Bord Altranais, The Irish College of General Practitioners and the Irish Practice Nurses Association. At the time it was felt that the pending Nurse Prescribing pilot would address some of the concerns identified, however in 2008, these concerns remain.
Medication protocols are:
“written directions that allow for the supply and administration of named medicinal products by a nurse or midwife in identified clinical situations. A medication protocol involves the authorisation of the nurse/midwife to supply and administer a medication to groups of patients in a defined situation meeting specific criteria and who may not be individually identified before presentation for treatment. An individually named prescription is not required for the supply and administration of medication when a medication protocol is in effect”

The legislative basis for medication protocols for the supply and administration of medication is the Medicinal Products (Prescription and Control of Supply) Regulations of 1996, and subsequent Regulations of 2003, which provides authority for hospitals to utilise medication protocols in order to meet patient/service-user need for medication management.

A review of these regulations is now opportune with a view to include an extension of same to all Primary Care health settings where GMS patients are treated. Such an extension would provide a less restrictive, more efficient, responsive and effective health service to the general public. Current health policy and service developments along with nursing professionals are cognisant of the demands on practice nurses to expand their scope of practice within appropriate parameters and with similar professional governance supports as other nursing professionals in the Irish Health system. The subgroup is in conjunction with other stakeholders preparing a discussion paper to be submitted to An Bord Altranais.

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APPENDIX I

Glossary of Terms

ANP/AMP-Advanced Nurse Practitioner/Advanced Midwife Practitioner

Advanced nursing or midwifery practice is carried out by autonomous, experienced practitioners who are competent, accountable and responsible for their own practice. They are highly experienced in clinical practice and are educated to Masters Degree level (or higher). An ANP/AMP demonstrates the core competencies of autonomy and expertise in clinical practice, clinical leadership and initiate research in his/her specialist area. The National Council for the Professional Development of Nursing and Midwifery accredits the posts of ANP/AMP(Appendix I).

CNS/CMS  Clinical Nurse / Midwife Specialist

A nurse or midwife specialist in clinical practice has undertaken formal recognised post-registration education relevant to his/her areas of specialist practice at a higher diploma level. Such formal education is underpinned by extensive clinical expertise which demonstrates the five core competencies. These posts are accredited by the National Council for the Professional Development of Nursing and Midwifery. (Appendix II)

G.P.  General Practitioner

HSE  Health Service Executive

HSE Transformation Programme 2007-2010

PDC- Professional Development Co-Ordinator (Practice Nursing)

Professional Development Co-ordinators (Practice Nursing) appointed by the HSE to co-ordinate and facilitate the strategic development of the discipline of practice nursing locally and nationally.

NCNM/National Council

National Council for the Professional Development of Nursing and Midwifery.
Accrediting body for Advanced Nurse and Midwife Practitioners and Clinical Nurse Specialists

NMPDU: Nursing and Midwifery Planning and Development Unit

PCCC: Primary Community and Continuing Care Directorate (HSE Pillar)

PN:  Practice Nurse
**PHN:** Public Health Nurse

**Primary Care:**
Primary care is an approach to care that includes a range of services designed to keep people well, promotion of health and screening for disease, to assessment, diagnosis, treatment and rehabilitation and personal social services. The services provide first-level contact that is fully accessible by self-referral and with a strong emphasis on working in partnership with individuals and communities to improve their health and social well being (Primary Care - A New Direction, 2001).

**Primary Care Team: (PCT)**
The Health Strategy proposes the introduction of an inter-disciplinary team-based approach to primary care provision. Members of the primary care team will include GPs, nurses/midwives, health care assistants, home helps, physiotherapists, occupational therapists, social workers and administrative personnel.

**Primary Care Network:**
A wider primary care network of other primary care professionals such as speech and language therapists, community pharmacists, dieticians, community welfare officers, dentists, chiropodists and psychologists will also provide services for the enrolled population of each primary care team.
APPENDIX II

Numbers of Practice Nurses who attended training in the following areas from 2003-2008;
Correct as at April 2009

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# Professional Development Co-ordinators for Practice Nurses Contact Details

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<th>Telephone</th>
<th>Fax</th>
<th>FAX Telephone</th>
<th>Additional Details</th>
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<td>01 2744201</td>
</tr>
<tr>
<td>Marian</td>
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<td>Unit 4, Central Business Park, Clonminch, Portlaoise Road, Tullamore, Co. Offaly</td>
<td><a href="mailto:Marian.Wyer@hse.ie">Marian.Wyer@hse.ie</a></td>
<td>057 9357858</td>
<td>057 9357871</td>
</tr>
</tbody>
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Exemplar Working Group *