

Managing older people close to home: the clinical case nurse manager in Ireland

This case study is part of a series of case studies looking at how Member States are developing new roles for nurses working in primary care in order to address changing population health needs. The case studies are intended to inspire and support policy-makers, instructors, managers and clinicians to recognize and strengthen the contributions of nurses in strengthening health systems.

Overview:

In the past decade, health services in Ireland have experienced a significant increase in unplanned admissions, applying pressure on tertiary health care, especially acute and emergency services. Similar to many countries in the WHO European Region, these services are especially challenged by the increasingly complex and chronic burden of disease among older people, whose needs are unmet in general practitioner (GP) services. To address this strain, the government has introduced the role of a clinical case manager in primary care, tasked with managing older people's needs.

Health challenges

In the past decade, the prevalence of chronic diseases such as ischaemic heart disease, lung cancer and stroke have been the most significant components of the burden of disease, although the incidence of Alzheimer's disease has increased rapidly, with an increase in prevalence of 28% in the past decade. In 2017, there were 1.3 million visits to emergency departments, with a 15% increase from the previous decade. With 15% of Ireland's 4.9 million people currently older than 65 years, increasing to 26% by 2050, acute health-care services are likely to become increasingly strained in the coming decades.

Primary care context

Primary health care in Ireland comprises GP-led multidisciplinary health care and social care teams. The aim in the past decade was to have 600–1000 primary care teams functioning within the country. The aim of the primary care team is to provide primary care services that are accessible, integrated and of high quality and that meet the needs of the local population.

The multidisciplinary teams comprise professionals who work closely together to meet the needs of the community (Box 1).

In addition, a network of other services is also available to support the primary care team, including psychology and counselling, audiology, podiatry, area medical officers, community welfare, dental, dietetics, ophthalmology, environmental health, community development, caregivers and others.

An emerging challenge before this role was introduced was the capacity for GP services to secure the continuity and efficiency of the range of services available to older people, whose needs increase in magnitude and complexity during their lifetime.

Box 1

Multidisciplinary teams

Teams can but do not necessarily include:

- general practitioner service;
- clinical case nurse managers;
- practice nurse services;
- community nurse services (public health nurse and community registered general nurse);
- home help and home care attendant services;
- occupational therapy services;
- physiotherapy services;
- speech and language therapy services; and
- social work services.

Key policies that support nursing

Various key policy documents in Ireland have recognized and described the expansion of nursing roles.

In 2000, a collaborative paper by the Health Service Executive recommended that nurses and midwives evolve and expand their roles. The key focus has been to enable nurses to become more competent, reflective practitioners, developing expert skills to meet patients' needs in a holistic manner.

Reinforcing this message, the strategy on primary care set out to ensure that all people in Ireland are able to access community nursing and midwifery services that both promote health and well-being and also provide appropriate care for people who require it. The strategy recognized that caring for complex patients with multiple illnesses in primary care requires additional time and can increase overcrowding in the hospital system. This requires an interdisciplinary model of integrated care that supports a holistic approach to patient and community needs.

In 2007–2012, the National Positive Ageing Strategy identified the need to take necessary steps to respond to the needs of the ageing population and was the forerunner to the development of future frameworks and policies. In 2008, the Strategy facilitated the creation of a Minister for Older People and Health Promotion and the Office for Older People. The purpose of the Strategy was to identify the provision that must be made and the plans that must be implemented to ensure the best quality of life for older people in Ireland in the future.

The similar theme continued within primary care in 2012–2015 with Future Health: A Strategic Framework for Reform of the Health Service. This government commitment to reforming the health-care model focused on increased care in the community setting. One of the primary visions is that patients' first point of contact in primary care should be capable of meeting 90–95% of health-care and social care needs, that they do not pay fees and for GPs to work in teams with other primary care professionals. The focus was to prevent illness and provide structured care for people with chronic conditions.

A new role for nursing

The Special Delivery Unit, a department within the Health Service Executive, was established in 2011 and tasked with reducing wait times for unscheduled and scheduled care and increasing capacity, access and performance within Ireland's health system. The Special Delivery Unit works closely with key stakeholders in hospitals, hospital groups, the National Treatment Purchase Fund and the Emergency Department Taskforce. Tasked with improving the pressures on the emergency departments and decreasing wait times, in 2013, the Special Delivery Unit recommended a new role for nursing: the clinical case nurse manager.

The key function of clinical case nurse managers is to identify and manage the complex care needs of appropriate older people in the primary care setting (Box 2). They are tasked with organizing the appropriate skills mix to provide holistic, optimal care across the health-care continuum, alleviating pressures applied to GP services and improving care through coordinating multidisciplinary teams across service boundaries through case management.

Box 2

Core tasks of clinical case nurse managers

- Coordinate care of the older person across settings, ensuring an appropriate multidisciplinary skills mix
- Deliver advanced and intensive nursing in a home care environment for older people with multiple complex conditions
- Provide a single point of contact for older people who need to navigate complex health systems
- Communicate and link community and acute services
- Facilitate discharges

This includes working with GPs, the primary care team but also specialists in the acute hospital to care for a frail older population in the community.

Using patient assessment tools such as the Comprehensive Geriatric Assessment, clinical case managers facilitate a seamless transition of relevant information across the services in a coordinated fashion and support older people and reduce the need for residential care. The success of the clinical case manager has been the ability to integrate with services in the acute hospital and primary care. The role is based in the community and works with the acute hospital in facilitating a shift to a community-based model of care. This enables greater access for patients and their families to specialist supportive care.

Another function is to provide continuous care between acute care services and primary care. To achieve this, the Health Service Executive recommends that the clinical case manager for older people and consultant geriatrician attend ward rounds 2–3 times weekly in hospitals and that a full multidisciplinary team meeting take place once a week, ensuring regular communication. Patients are discharged to their primary care team and referred back to specialist hospital-based services as required. The details of the interventions and plan of care for the patient are disseminated to all health-care and social care professionals involved in the patient's care. The key to the success of the clinical case manager role is the continuous collaboration between all services to ensure the provision of the highest standards of patient care.

Implementing the new role for nursing

Selection of candidates. Recruitment for the role was achieved through the national recruitment service. Suitable candidates were shortlisted by completing specific competency-based criterion, including completing case-based scenarios.

The role was implemented at the national and subnational levels by developing a job description that was essential to formalize and support the role. The criteria requirements include registered nurse experience,

with a minimum of five years of post-registration experience in community care or care of older people. This ensures competence in the wide range of skills required, including clinical, nutritional, functional, psychological and social care.

The role of clinical case nurse manager requires clinical and academic experience to be successful. The experience of this nurse is critical when working across the different specialities and care boundaries to facilitate optimum outcomes for patients.

Continuing professional development.

Further education and training are available to the clinical case manager through the national nursing and midwifery office. This office provides funding and education that allow nurses to develop and enhance their skills. Under the Nurses and Midwives Act 2011, Part 11, registrants, employers and the Nursing and Midwifery Board of Ireland have responsibility for maintaining professional competence.

Multidisciplinary culture. The post was also supported and championed by members of the multidisciplinary team by welcoming the role, responding to the clinical case nurse manager's requests for services and by disseminating information about the role across the acute and community services.

Governance and legislation

At the national level, this post was introduced on the recommendation of the Special Delivery Unit within the Health Service Executive and is now embedded in the Integrated Care Programme for Older Persons.

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Resource toolkit:

For policy-makers

- Review of scope of practice for nursing and midwifery. Dublin: Nursing and Midwifery Board of Ireland; 2000 (<https://www.lenus.ie/bitstream/handle/10147/45072/6797.pdf?sequence=1&isAllowed=y>).
- Primary care – a new direction. Dublin: Department of Health and Children; 2001 (<https://assets.gov.ie/12630/75215c912d9c4e06b43dd56a3d4c1e86.pdf>).
- National Positive Ageing Strategy. Dublin: Department of Health; 2013 (<https://assets.gov.ie/11714/d859109de8984a50b9f2ae2c1f325456.pdf>).
- Future health: a strategic framework for reform of the health service 2012–2015. Dublin: Department of Health; 2012 (<https://assets.gov.ie/18890/d44343d71ee4484e85e7e2b45f693107.pdf>).

For clinicians

- Specialist geriatric team guidance on comprehensive geriatric assessment. Dublin: National Clinical Programme for Older People; 2016 (CGA) (<https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/comprehensive-geriatric-assessment-document-.pdf>).

This ensures standardization of role development, appropriate governance structures and alignment with acute hospital and community services. At the local organizational level, nursing leadership from primarily the Director of Public Health Nursing, community and acute nursing has facilitated the development of the role and its integration across the services.

National Clinical Programme for Older People.

The Integrated Care Programme for Older Persons and the National Clinical Programme for Older People were established to scale up the Ministry of Health's capacity to focus and respond to the growing needs of older people. To progress the implementation of the Integrated Care Programme for Older Persons at the local level, a steering committee was established between acute and community services. Representation from all aspects of health care and social care enabled the development of pathways and access. This was critical to implementation, with clearly defined roles and responsibilities for different professionals and different clinical governance structures. This enabled links and pathways to be created, allowing timely access for patients to the relevant services.

Public response

General feedback from older people accessing the service and their families has been very positive. The public values access to a professional who can coordinate care and signposting to services based on need and helping patients to make informed decisions about a range of community and acute hospital services.