Public Health Nursing in Ireland:
Demonstrating interventions from practice

Validating public health nursing actions
using the American Intervention Wheel
This document should be cited as follows:

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Foreword by the President of the Institute of Community Health Nursing

The Institute of Community Health Nursing is honoured to publish the first edition of the Irish Intervention Wheel: *Public Health Nursing in Ireland: Demonstrating interventions from practice.* Making public health nursing visible by identifying and naming interventions which are core functions of practice will demonstrate the public health contribution of the largest group of nurses working in the primary care setting to the health of the Irish population. The Institute of Community Health Nursing (ICHN) is committed to raising the profile of the public health nursing service through research and international collaboration.

The ICHN is a professional and educational body representing community nursing in the Republic of Ireland. Incorporated in 1985 to promote community nursing services through education, development and research the Institute established four special interest groups in 2011. These groups provide an opportunity for members to network with colleagues and to share models of best practice in nursing.

The Population Health Special Interest Group (PHIG) continued the work of identifying PHN interventions initiated during the Population Health Information Tool project. International evidence directed the group to the work of American PHNs who developed an Intervention Wheel outlining population based public health practice. The PHIG group validated the American interventions over a two year period and compiled a collection of stories from day to day practice to describe these PHN actions within the Irish context.

I would like to commend the Population Health Interest Group for their dedication and expertise in compiling the Irish Intervention Wheel stories which will provide greater insight to the wide and varied contribution of the Irish public health nursing service to the health of the population.

It is fitting that these stories are launched at the 3rd International Public Health Nursing Conference in the National University of Ireland in Galway in the presence of so many of our national and international colleagues and in particular the authors of the American Intervention Wheel.

Ms. Ann Corridan
President
Institute of Community Health Nursing
17th July 2013
Introduction from the co-authors of the American Intervention Wheel

The American Wheel of Interventions emerged from an observed need for a common language, a lexicon, for public health nurses to use in describing their common actions regardless of a particular work assignment. The time was the mid-1990’s in Minnesota; those observing were public health nurses who provided consultation to local health departments on behalf of the Minnesota Department of Health. With the assistance of a federal grant, the Wheel and its use was refined through an extensive literature search and field testing with public health nurses in four additional upper Midwest states.

Since the final manual, “Public Health Interventions: Application for Public Health Nursing,” was made available online in 2001 both PHNs in practice and PHN educators have adopted it widely. The Wheel has been translated into many languages, incorporated into practice models for public health nursing departments in the States as well as abroad, and provided a model for numerous academic papers and dissertations. In truth, we really have no idea how wide and far the Wheel has found purchase. That is why we are very excited to collaborate in the development of “Public Health Nursing in Ireland: Demonstrating Interventions from Practice” by the ICHN Population Health Interest Group.

In reading the public health nursing stories from Ireland we are struck by the similarities of the work and yet subtle differences. Some is attributable to differences in use of the English language. In Ireland there are “mums,” for instance, while in America we have “moms.” Mums or moms, however, their circumstances are strikingly similar—inadequate income, poor housing, children with special needs. And, of course, there are significant differences in how health care services are delivered in each country. In Ireland there is a public system providing health care to all supplemented by a private system for those who can afford it. In America there is a private health insurance sector dependent on employment and a publically-funded supplementary system that provides insurance for those who meet certain income and asset guidelines.

However, there is no guarantee of access to health care services. Although the 2010 passage of the Affordable Care Act by the American Congress holds the promise of remedies, much remains to be seen whether it can meet the demands placed on it to expand insurance coverage, control health care costs, and improve health care outcomes. In America, for instance, no newborn is assured the offer of a follow-up home visit by a public health nurse.
In America nurse and social activist, Lillian Wald (1867-1940), first used the term “public health nurse” to describe the work she and her staff of nurses carried out through the Henry Street Settlement House among the masses of immigrants arriving in New York at the end of the nineteenth century. The enduring symbol of her era, the “black bag,” continues to symbolize the profession in America.

Even though actual use of the bag ended long ago, it still is common in America to ask public health nurses if they’ve “carried the bag” when inquiring about their experiences in public health nursing. After reading “Public Health Nursing in Ireland: Demonstrating Interventions from Practice,” we can say that Irish public health nurses “carry the bag” also!

Linda Olson Keller, RN, DNP, APHN-BC, FAAN
Susan Strohschein, RN, MS, APHN-BC
University of Minnesota School of Nursing, Minneapolis, MN
25th June 2013

Figure 1: Henry Street Public Health Nurses about 1912

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25th June 2013

1 Jewish Women’s Archive “Nurses in a Row” Retrieved from: http://jwa.org/media/nurses-in-row
Acknowledgements

The group would like to acknowledge the work of nurses who contributed to the Network Cafe process in September 2011.

The group would like to thank the authors of the American Intervention Wheel for providing images of the Wheel for this edition.

The group would like to thank the following who provided the untitled photographs presented in this edition:

- Nurses and patients from the RTE programme ‘The Nurse’
- Members of the Community Mothers Programme
- Nurses and patients from the Population Health Information Tool Video, the PHIT DVD (2008) was funded by the Office of Tobacco Control
- The Institute of Community Health Nursing

The group would like to thank Pavee Point Traveller and Roma Centre for providing permission for photographs on pages 59 and 61 copyright of Derek Speirs.

The group would like to thank Ms Mary O’Dowd and the Institute of Community Health Nursing for providing dedicated support to this project.

Please Note: The photographs used and acknowledged in this document provide visual prompts for the PHN interventions described and bear no relationship to the individual patients described in any of the stories.
Chapter 1
Background to project

The public health nursing service is the largest group of nurses employed in the Irish community setting, and in order to respond to identified population health needs the public health nurse (PHN) service provides a range of nursing interventions within geographically defined caseloads. These interventions span the lifecycle from cradle to grave encompassing maternal and child health and protection, health promotion and acute and chronic care and bedside nursing. Despite this generalist role function, aspects of the work of the PHN service remain invisible and poorly described within the current Irish primary care setting (Begley 2004). A publication to celebrate the 20th anniversary of the ICHN provided insight into some practice initiatives undertaken by PHNs at that time (ICHN 2005).

This lifespan approach is considered as core to Irish PHN services, as identified in the Report of the Commission on Nursing (GOI 1998), which affirmed the geographic area based model of public health nursing. Public health nursing services are the prime providers of nursing care in the community and a range of nursing roles is required to respond to changing health and social care needs within a primary health care model (HSE 2006).

Previously, nurses working together from both the north and south of Ireland developed a model for practice development entitled ‘Working for Public Health’ (Department of Health, Social Service and Public Safety and Department of Health and Children 2003). The client was identified at individual, family and community levels, the lifespan of the client described from inter-uterine to late adult and the nursing actions as primary, secondary and tertiary using micro, meso and macro levels of intervention (DHSSPS & DOHC 2003 p14). However this model did not specifically name the community nursing interventions employed when working in and for public health.
This gap in information has made PHNs aware of the significance of naming public health actions they undertake when responding to the needs of individuals, families and population subgroups in order to make their work visible.

Public health nurses in one geographic region came together in 2006 and developed a health information management framework called the Population Health Information Tool (PHIT) to address health information needs. The PHIT framework identifies and makes visible individual / family and population health needs through a continuous system of patient registration and data analysis (Health Service Executive 2011); it has been implemented in one local health office area in Dublin. A pilot project, to migrate the paper version of the PHIT to an electronic solution, was funded by the Institute of Community Health Nursing and is currently underway in 2013.

Public health nurses and Registered General Nurses (RGNs) working in the PHN service, who participated in the PHIT project working and implementation groups, agreed the core population health values of equity and promotion of health (HSE 2011). These nurses have created a health information management system providing an equitable community nursing service based on assessed need and guided by the following definition of population health:

‘A Population Health approach is one which promotes and protects the health of the whole population or subgroups, with particular emphasis on reducing health inequalities’ (HSE 2008, p.3).

Population health priorities include the need for comprehensive community health assessments, based on wider health determinants of health, to resource health care whilst offering access to all members of the population. This is reflected in Irish, UK and American nursing and health care literature (DOHC 2001; HSE 2008; DOHSSPS & DOHC 2003; MDH 2001). Public health improves population health through interventions with individuals, families, communities and population groups and is defined as:

‘the science and art of preventing disease, prolonging life and promoting health through organised efforts and informed choices of society , organisations, public and private, communities and individuals” (Wanless 2004, p.27).
Public health interventions are initiated daily by nurses in the primary care setting and Irish PHNs are educated and guided in this practice by the philosophy of primary health care originally outlined by the World Health Organisation (WHO) Declaration of Alma Ata (WHO 1978). This philosophy is supported by the International Council of Nurses (2008) and is underpinned by the following principles (College & Association of Registered Nurses of Alberta (2005):

1. Is evidenced based
2. Uses appropriate technology
3. Promotes community participation in decisions about health services
4. Is provided at a cost the community can afford
5. Encourages self care and empowerment of community members
6. Is the first level of contact with the health care system
7. Brings health care as close as possible to where people live, work, and play

A review of the international nursing literature, undertaken during the process of developing the PHIT framework, highlighted work already undertaken by American PHNs. Public Health Nurses based in Minnesota created and named an “Intervention Wheel” to identify and name public health actions or interventions that they undertake. They define interventions as: Actions taken on behalf of individuals, families, systems, and communities to improve or protect health status (Minnesota Department of Health 2001). These seventeen interventions are underpinned by a set of ten assumptions (MDH 2001).
These ten assumptions reflect the population health priorities outlined above defining a public health nursing practice which operates at the population level emphasising all levels of prevention and embracing the wider determinants of health and one which is informed by an assessment of community health. They articulate three practice levels; community, systems and individual / family, the use of the nursing process at all three levels and the interventions or actions taken at these levels to improve or protect health status. A set of values and beliefs outlined in the Cornerstones of Public Health Nursing Practice (MDH 2004) accompanies the interventions explaining the overall motivation and challenges for public health nursing practice.

The seventeen public health interventions or actions of the Intervention Wheel are visually represented in a colour-coded wheel comprising five wedges. Interventions are described at three levels: individual / family, community and systems, and importantly population-based practice incorporates all three levels and does not exclude individual / family levels of PHN practice (Keller et al 1998) (Figure 3).

The Intervention Wheel provides a conceptual model for PHN practice and was developed, fifteen years ago, through a grounded theory process. It aimed to highlight and make visible the core functions of PHN practice and has been presented as a model for practice in the United States of America and internationally (Keller et al 2012).

A book of Intervention Wheel stories described the experience of American PHNs from their perspective of day-to-day practice (MDH 2006) and an outline of population-based competencies for student PHNs was subsequently published (Schaffer et al 2010) and a clinical manual for entry-level public health nurses (Garcia et al 2011).

In 2007 nurses involved in the PHIT project initiated communication with authors of the Wheel to explore how their interventions worked in practice and an oral validation of the interventions was undertaken. The nurses working on the PHIT project agreed that the description of the American interventions, such as ‘collaborations’ and ‘health teaching and emotional advice’, could be found as early as 1937 in the Irish nursing literature.
An example of this identified district nurse Mary Quain when describing her nursing work in a remote Galway community, during an interview recorded by Dr. T. Meehan, outlined nursing actions which encompass surveillance, disease and health event investigation, outreach, screening, case finding, referral and follow up, case management, delegated functions, consultation, community organizing and advocacy (Meehan 2005, p122-137). In another publication, Mary Quain is described by her Superintendent, as a ‘conscientious kindly nurse, very gentle and considerate with the patients’, she was also noted to ‘have the Irish language and was a cyclist’ (Prendergast & Sheridan 2012, p196-197).

Prendergast & Sheridan (2012) describe in detail the domiciliary healthcare contribution of district nursing services between 1890 and 1974 to those most in need. Claiming that these services which provided a ‘stable and supportive presence to communities’ and which were dedicated to improving the standard of living for their patients were for the most part unacknowledged (Prendergast E. & Sheridan H. 2012, pxiv).

Figure 2: Nurse Doyle, Lady Dudley’s Scheme 1935

Their rationale for compiling a historical profile of the district nursing services is similar to that of the authors of the American Intervention Wheel and of this ICHN publication; to make the work of public health nursing visible.

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2 This photograph is part of the Conrad Pim collection which is currently held at the National Archives of Ireland
In order to progress the work of highlighting the complexities in the PHN role and to address recommendations of the PHIT (HSE 2011, p.8) the ICHN agreed to progress the work of validating the American PHN Wheel within the Irish context.

Figure 3: The American Intervention Wheel
Minnesota Department of Health (2001)
Chapter 2
The Validation Process

The work of validation of the Intervention Wheel progressed in earnest when a dedicated professional group, representing community nurses nationally, was convened as a special interest group under the Professional Forum of the ICHN in 2011.

International Collaboration

Communication had been initiated previously in 2007 by the PHIT project group resulting in dialogue and support from one of the Wheel co-authors Susan Strohschein MA APHN-BC. Ms Strohschein responded to all requests for information and provided clarification on questions which arose during this early part of the validation process.

Another co-author of the Wheel, clinical Professor Linda Olson Keller, visited Ireland in 2010 and presented a paper on the Wheel at the annual ICHN conference (www.ichn.ie). Professor Keller undertook a site visit to a Dublin north inner city health centre and accompanied PHNs on home visits at that time noting the similarity of their work with that of PHNs working in Minnesota.

Members of the ICHN subsequently attended a second International conference of Public Health Nursing in Minnesota in 2011 fostering engagement with an even wider international network of PHN colleagues. It was agreed by the conference participants that the ICHN would host the third international PHN conference in 2013 in Ireland.

Formal validation from the authors of the American Intervention Wheel was given when Ms Strohschein and clinical Professor Keller reviewed the document and compiled the introduction to this first Irish edition of interventions from practice.
Irish Development

The Population Health Interest Group (PHIG), convened in 2011 by the ICHN, comprises PHN service clinicians and managers, practice development and specialist nurses and an academic, who all have a special interest in population health and who agreed to complete a process of validation of interventions.

The overall aim of the validation process was to provide a set of interventions that fully described the role and boundaries of Irish PHNs. Acknowledging, that nurses need to be competent in all 17 interventions (but may not employ all interventions depending on their role requirement) and that a governing population health approach supports PHN service skill mix, workforce planning and improves the visibility and credibility of the PHN service nationally.

Further development work for the PHIG group (beyond this report) will be to outline competencies needed to support the identified interventions which can contribute to: the An Bord Altranais agus Cnaimhseachais na hEireann requirements and standards for PHN registration (An Bord Altranais 2005), PHN curriculum development (there is currently no registration for community RGNs working in the PHN service) and further inform population datasets collected by a future electronic PHIT.

The overall results of PHIG development work will provide a governance framework for the collection of public health nursing service interventions and outcomes and key performance indicators facilitating comparison of the PHN service nationally and internationally. Such a framework will underpin the future expansion of PHN service roles and practice development needed to deliver the PHIT community assessment and caseload management model (HSE 2011, p. 8) in primary health care in line with the vision, goals and framework for action identified in Healthy Ireland (DOH 2013).

The five wedges of the Intervention wheel, which grouped similar interventions, were then delegated to five individual PHIG members who agreed to take responsibility for defining, searching for and compiling examples which would correspond to their particular wedge in order to provide further evidence of validation. The PHIG members identified and reviewed all available literature published by the Wheel authors. Each public health intervention was discussed at the three practice levels: individuals and families, communities and systems and stories from practice were provided as evidence of each intervention in contemporary Irish PHN practice. Some differences in how nursing terms were used between the two cultures were noted during this procedure.
A template of the seventeen interventions included the definition assigned by the original authors (MDH 2001), examples from American PHN practice and corresponding examples from the Irish context, was compiled in order to provide a framework to facilitate group discussion and to further populate the Irish Wheel.

The annual ICHN conference provided another opportunity for the PHIG members to share the work of the group with a wider audience. Information on the Intervention Wheel was provided in an oral presentation followed by a network cafe exercise. This enabled exposure of the Intervention Wheel to a select group of conference participants.

A network cafe (Brown & Isaacs 2005) is an informal meeting which builds on the strengths of having structure while supporting the creativity of more social types of gatherings. Following the oral presentation, network cafe participants were invited to join one of five tables which represented each wedge of the wheel hosted by the group member responsible for that wedge. Fifteen minutes was allowed for discussion at each table and then a prompt was given to participants to move to the next table in clockwork fashion. This allowed participants opportunity to make a contribution to each wedge, whilst host members introduced each session provided prompts and clarification and recorded all participants’ contributions.

The participants provided exemplars from practice to match the interventions in the template and by their comprehension and interpretation of the five components of the Intervention Wheel provided further endorsement. The information gathered in the network cafe exercise was added to the original template to provide a more robust interpretation of the interventions and then was circulated to all five host members for agreement.

The PHIG group decided at that point that to progress this work further they would need support from a third level institute and invited Dr. Kate Frazer from University College Dublin to join the group to advice on the next steps of validation. The next steps agreed were:

- Documenting the pathway of the validation in the Irish context.
- Acknowledging that validation against the Minnesota Intervention Wheel provides an evidence base standard with which to compare the Irish PHN practice interventions.
- Ensuring that each intervention validated would have a clear and comprehensive definition which had meaning in the Irish context which led to:
  - Holding of a workshop meeting in University College Dublin where members brought stories from practice for each of the 17 Interventions which were discussed in depth and then revised by the group.
Subsequent follow-up revision and review meetings when the stories were checked for representation and agreement within the group that each story primarily described an identified intervention (most stories as expected described multiple interventions).

- Promoting wider circulation of the developed template which would assist in populating Irish interventions and group members volunteered to request stories from their practice areas.

- Editing and formatting of the Irish stories into book format providing a background to and description of the process of validation.

- Requesting formal validation from the American authors of the Intervention Wheel for its use and adaptation within an Irish context.

- Publishing of the collection of validated practice-based Irish stories; demonstrating the adaptation of American public health interventions within an Irish context.

The following five chapters provide stories representing practice-based interventions from each of the five colour coded wedges relating to the Irish public health nursing experience. Some wedges are more relevant to a particular level of intervention for example the red, green and blue wedges are used by PHNs who direct their practice towards individuals, families and groups.

Many of the Irish stories include all three levels of intervention but Irish nurses are more likely to describe all intervention levels but report care at the individual / family level only. It is a challenge for Irish PHNs to separate out their nursing interventions so that the community, systems and individual / family levels become more explicit, making their role more visible.

In line with the ethics of An Bord Altranais agus Cnaimhseachais na hEireann (An Bord Altranais 2000) all stories documented in this publication have been made anonymous. A diagram outlining the process of validation of the interventions is below.
The Wheel was developed by PHNs in the USA in 1998 through a grounded theory process in an attempt to highlight and make visible the core functions of PHN practice.

The PHIT project team 2006-2008 discussed the relevance of the 17 Interventions to Irish PHN practice and made contact with Sue Strohschein.

A visit to Ireland by Linda Olson Keller in 2010 allowed health centre site visiting Linda noted the similarity of the Irish and American PHN’s role.

Ongoing collaboration resulted in attendance at the 2nd International PHN Conference in Minnesota 2011.

An Irish Intervention Wheel would:
- Provide a set of interventions to describe the Irish PHN role
- Outline the competencies needed to support the interventions contributing to ABA Requirements & Standards for PHN Registration and the PHN Curriculum
- Acknowledge that nurses need to be competent in all 17 Interventions
- Identify and support research skills needed by PHN clinicians to deliver the community assessment aspect of the PHIT Caseload Analysis Process
- Provide a Framework for expansion of PHN Roles and practice development in primary care
- Further inform population datasets
- Provide a governance framework for the collection of PHN outcomes and KPIs

A Population Health Interest Group (PHIG) was convened in 2011 by the ICHN to progress the validation process.

Members of the PHIG represent clinicians, managers, practice development and academia.

The PHIG members reviewed and discussed literature in relation to the Wheel in order to further the process of validation within the Irish context.

Each of the 5 wedges was assigned to a PHIG member who agreed to take responsibility for understanding the interventions in that wedge and provide examples in the Irish context.

A template of the 17 (American and Irish) Interventions was compiled to facilitate group discussion.

The Wheel was presented at the ICHN Conference in September 2011 by a PHIG member followed by a Network Cafe exercise to assist with the validation process.

Stories from practice for each of the 17 Interventions were discussed in depth and further revised by the group at a day workshop in UCD.

Follow up revision and review at a group meeting further revised and checked stories for representation i.e. that the story selected described the intervention identified.

Editing and formatting of the Irish stories into book format providing a background and a description of the validation process.

Formal validation from the American authors of the Intervention Wheel for the Irish Stories.

Publication of the validated Irish Stories by the ICHN.
Chapter 3
Red Wedge

The first wedge of interventions actively supports the finding of cases that are not known to the public health nursing service in order to link them to appropriate services. The five interventions include 1) surveillance 2) disease and health investigation 3) outreach 4) screening and 5) case finding.

1) Examples given in the American Intervention Wheel for surveillance at systems level include identification of all children with special needs to multidisciplinary early intervention teams. Irish PHNs have provided similar examples from information systems which collect information from birth notification to population health outcomes.

2) American examples for disease and other health event investigation include participation in a regional pandemic flu outbreak, a corresponding example is given in the Irish context where the nurse describes the management of an outbreak of pertussis other Irish examples include management of outbreaks of head lice and in relation to the H1N1 flu pandemic.

3) Examples of outreach in the American context include: education of elderly Hmong population regarding depression, whilst the Irish context describes the PHN outreach service to Travellers. Tuberculosis outreach contact tracing in the community and the Community Mothers Programmes are other examples within the Irish context.

4) Examples of screening in the American context include screening for postnatal depression. The Irish example describes screening during a routine 7 to 9 month infant developmental clinic. Screening for post-natal depression, metabolic disorders, vision and hearing in schools, falls risk in the elderly are other examples identified within the Irish context.

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5) Case finding in the American context describes follow up with a family who have language difficulties and who are living illegally in the USA and do not bring their infant to scheduled health appointments. The PHN follows up on this case following the family through to diagnosis of hypothyroidism addressing the wider social determinants of health. The Irish example of case finding arises from a similar example of non-attendance at follow up screening appointments finding and managing a case of stress within the family system.

Figure 5: Intervention Wheel / The Red Wedge
Surveillance

Describes and monitors health events through ongoing and systematic collection, analysis, and interpretation of health data for the purpose of planning, implementing and evaluating public health interventions four.

The PHN is linked initially into systematic data systems with birth notification data within the child health surveillance system. Following a birth notification visit and subsequent post natal visits I had developed a good relationship with Ruth’s mum and at each meeting I used a Parent Held Record (PHR) when assessing, screening, or identifying any risk and identifying any needs five.

The 7 to 9 month developmental clinic is a nurse-led clinic held at the local health centre. Two PHNs manage the clinic and any resulting referral pathways to other services for example: speech and language therapy, ophthalmology or subsequent review by Area Medical Officer (AMO). Ruth and her mum had been invited to attend the clinic and her mum brought her along for a developmental screening assessment.

During the assessment I noticed that Ruth’s motor development was delayed, she had not reached the established milestones for her age. I discussed Ruth’s progress with her mum and asked if she had noticed any problems; she was unaware. After discussing my findings with her mum, and gaining her consent, it was agreed that I would refer Ruth for further assessment by the AMO for a thorough medical review. Following Ruth’s assessment by the AMO it was confirmed that Ruth had delayed motor development. She was subsequently referred to a Paediatrician for further investigations and was diagnosed with monoplegia, due to a birth defect, resulting in a physical disability.

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Ruth was referred to an early intervention team. The PHN is part of the early intervention team providing multidisciplinary assessment and intervention for children who are aged 0 to 5 years and who are diagnosed with developmental delay. As part of this multi-disciplinary team, I attended all meetings with the Paediatrician, Speech and Language Therapist, Occupational Therapist, Social Worker, Physiotherapist, Special Needs Assistant and Ruth’s parents. A programme of care was developed and put in place for Ruth and her parents.

The early intervention team provides a family-focused service viewing the child from a holistic perspective within the context of the family. During my follow-up visits, I provided information about this service and other relevant benefits and health entitlements to Ruth’s parents. During subsequent assessments I used screening tools such as Ages and Stages Questionnaire6 and ensured my assessments were family-centred and involved joint planning and evaluation.

Ruth, with the help of a special needs assistant, was able to attend the local pre-school. She is now 6 years old and is attending the local primary school with the support of, a full-time special needs assistant. Due to her speech difficulties, which presented some communication challenges, Ruth and her family have learned sign language; as have her teacher and special needs assistant in school. Her mum is availing of a number of allowances and services including: domiciliary care and counselling support.

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6 Ages and Stages questionnaire - [http://agesandstages.com/](http://agesandstages.com/)
Surveillance

Public health nurses, in one regional local health office, came together in 2006 to develop a system describing individual / family and community health needs, by systematic collection, analysis and interpretation of health data based on individual / family patient registration and caseload analysis, for the purpose of service planning and resourcing. The following core registers subsequently allow PHNs to group comprehensive data on every patient admitted to their geographic caseload at predetermined intervals: ‘Family Health’, ‘Acute Care Episodes’, ‘Chronic Sick and Disability’ and ‘Older Adults’.

Quarterly and annual data reporting identifies the dependency of patients based on a four-item patient dependency scoring (health promotion need, acute episodic care need, chronic stable care need and chronic complex care need) the nursing activity within caseloads and the type of nursing interventions needed.

The annual Caseload Analysis meeting with the PHN line manager allows the PHN:

- To discuss the demographic and epidemiologic profile of her geographic area
- Outline the services already in situ
- Detail the PHN responses to community needs and to those of ‘cause for concern’ families
- Identify the professional and practice development needs of the PHN caseload manager
- Develop a plan for community based public health interventions such as parenting support groups, post natal depression screening, multidisciplinary assessment for falls risk in the elderly, smoking cessation programmes.

This surveillance system, the Population Health Information Tool (PHIT) (HSE 2011), has demonstrated that it can continually report individual / family and community health needs and provide an evidence base for service resourcing, planning and evaluation.

The system has identified that PHN caseloads in the least deprived geographic areas with a SAHRU® score of 1 or 2 have very low rates of Low Birth Weight (LBW) babies (2 to 3%); caseloads in the most deprived areas have higher than national average rates of LBW (areas with SAHRU scores of 9 or 10 may have LBW rates of 8 to 9%). The average national rate of LBW is 5% (ESRI 2012). In 2012 a funded project is in place to support the migration of the paper based PHIT to an electronic solution.

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8 Small Area Health Research Unit (2007), Department of Public Health and Primary Care, Trinity College, Dublin www.sahru.ie
Disease and Health Event Investigation

Systematically gathers and analyzes data regarding threats to the health of populations, ascertains the source of the threat, identifies cases and others at risk, and determines control measures.10.

Following an outbreak of pertussis in one health board region, two children were subsequently hospitalised. Provision of information and management of outbreaks of infectious diseases, including notification, are the responsibility of local Departments of Public Health Medicine. The local Department of Public Health Medicine provided written information about the outbreak of pertussis to local maternity units, crèches and pre-schools, in addition to informing the primary care team.

When the outbreak was first identified the Assistant Director of Public Health Medicine, with responsibility for immunizations, contacted local PHNs, General Practitioners and Practice Nurses to ensure that the immunization records of infants were up to date. This current outbreak did not result in a major vaccination campaign because the families involved were identified as isolated cases and were successfully treated.

The media, through local radio and newspapers, mounted a campaign to inform the public of the outbreak and provided information on vaccination programmes; to allay fear and anxiety. I visited crèches, pre-schools and contacted parents to inform them of the importance of the immunization programme within the scheduled time frame. I used this phone contact with parents to allay their fears about the outbreak and provided information on the vaccine and its safety. Although this significantly increased my workload (and that of my PHN colleagues), it resulted in a positive outcome as the uptake of the vaccine also increased.

The local controls put in place to prevent any further outbreaks were:

- A Tdap immunization schedule for first years in second level schools was introduced to school's immunization programmes from September 2011, replacing Td vaccine.\textsuperscript{11}

- National Immunisation Guidelines (2008) recommend that children aged 11 to 14 years should receive a booster dose of vaccine to prevent pertussis as more cases are occurring in adolescents and adults due to waning immunity that occurs over time combined with the reduction in natural boosting.

- Students identified by the PHN service as not having previous immunizations or an incomplete course, now receive an information letter from the PHN service advising them and their parents of the appropriate vaccinations in line with the National Immunization Guidelines for Ireland (2008).

The PHN plays an important role in educating and advising parents that a persistent cough lasting more than two weeks could be an indicator of pertussis and to contact their GP. Ensuring that children are up to date with their immunizations involves liaising with GPs, checking registers and encouraging vaccination in other vulnerable groups. Additionally, the PHN visits crèches and pre-schools and provides telephone contact to mothers, especially to those who have not had their children vaccinated as they are a high risk group. The PHN advises childhood vaccination to all parents and provides a copy of the HSE booklet: *Your Child’s Immunisation - A Guide for Parents*\textsuperscript{12}.

\textsuperscript{11} Health Service Executive (2008) Immunisation Guidelines for Ireland (with updated corrections and amendments September 2011)

\textsuperscript{12} Health Service Executive (2008) Your Child’s Immunisation, A guide for parents HSE, Dublin. \url{http://www.immunisation.ie}
Outreach

Locates populations-of-interest or populations-at-risk and provides information about the nature of the concern, what can be done about it, and how services can be obtained\(^\text{13}\).

There are a small group of Travellers living in a halting site within the PHN’s catchment area. The PHN, through visiting and observation, has become aware of the poorer health status of Travellers\(^\text{14}\), compared to the settled community within the same location.

The difficulty in accessing improved living conditions for Travellers made me realise the dilemma it is for them trying to access services, or trying to engage with local statutory bodies to improve their living conditions. Travellers have poorer health outcomes in comparison with the population in Ireland and have increased rates of premature mortality and morbidity (AITHS 2010). Additionally, Travellers have lower rates of literacy, and have difficulty accessing health care services (AITHS 2010)\(^\text{15}\).

Locally a specialist PHN has been assigned to work with Travellers in the area to improve their health outcomes. She works in partnership with the local PHN service and acts as a resource in providing support and education in identifying Traveller needs. I liaised with this specialist PHN.

I identified a need to trace children who had not received immunizations and others who had not attended for developmental screening. This resulted in, myself the specialist PHN assigned to Travellers and the area medical officer providing developmental screening clinics and immunizations clinics at the halting site.

Subsequently there is evidence of an increase in the uptake of health services and active participation in care given through good dialogue and communication. Literacy levels have improved this has led to an increased awareness of the need for services; also increasing confidence and self-esteem amongst Travellers in the area.

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\(^{14}\) The Equal Status Act (Government of Ireland, 2002) defined the Traveller Community as follows: ‘Traveller community means the community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions, including historically, a nomadic way of life on the island of Ireland’

\(^{15}\) Department of Health and Children (2010) All Ireland Traveller Health Study (AITHS): Our Geels, School of Public Health, Physiotherapy and Population Science, University College Dublin
The role of the PHN is:

- To act as an advocate for the Traveller community
- To collaborate with the designated PHN assigned to Travellers
- To promote health and build confidence
- To follow up on developmental screening and immunization
- To promote Women’s health in the Traveller community

Working within the Traveller community and promoting health overlaps at individual / family, community and systems level. The importance of having a designated PHN for Travellers is essential to build trust and improve health outcomes.
Screening

*Identifies individuals and families with unrecognized health risk factors or asymptomatic disease conditions in populations* [16].

Jack attended a routine 7 to 9 months developmental clinic accompanied by his mum. The developmental clinic is nurse-led and is managed by two PHNs. During the screening assessment I noticed a squint in Jack’s left eye. I asked Jack’s mum if she had any concerns about this or if there was a family history of first degree squint (amblyopia).

Following discussions with Jack’s mum, I followed the criteria laid down by Best Health for Children (BHFC) (2005) [17] and with her consent I referred Jack to the ophthalmic clinic for further review. Jack was reviewed by a Consultant Ophthalmologist eight weeks following my referral.

According to the BHFC programme (2005), the aim is to improve the quality of vision screening for pre-school children, undertaken by PHNs. A squint is present when the eyes are not aligned at all times and it can be convergent (inwards), divergent (outwards) or be vertically displaced (BHFC 2005). Squints can be associated with premature births, children with physical and mental disabilities, or with families with a positive history of squint or refractive error.

Jack was reviewed again by the Ophthalmologist (6 month review) and he was advised to wear glasses and a patch on one eye. Jack is now two years old continues to wear his glasses and a patch on one eye for four hours each day. He attends a specialist eye clinic for follow-up review. In my follow-up home visits with Jack, I discussed how he was managing with his mum and I also observed that she was ensuring Jack followed the treatment regime.

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Case Finding

Case finding is a one-to-one intervention and therefore operates only at the individual/family level. As such, case finding serves as the individual/family level of intervention for surveillance, disease and other health event investigation and outreach. Case finding is frequently implemented to locate those most at risk.18

Normal child development requires child development screening which is offered at birth, three months, seven to nine months, two years and three years.19 Even though this service is not mandatory in order to support the health and protection of children, public health nurses follow up with cases of non-attendance. I called to a house to screen two children out of a family of nine who had failed to attend on numerous occasions to the health centre. After I had completed the screening assessments, I inquired as to the well-being of the parents.

I qualified this question after they said they were “fine” by asking why they had not visited the clinics. The dad admitted that he was recently made unemployed and although he was in receipt of Jobseekers Benefit from the Department of Social Protection www.welfare.ie, he found it difficult to accept being unemployed and to manage the reduction in his earnings. He said that his wife had been unwell for several months and displayed signs of extreme anxiety he stated that she was lying in bed at night until 6am, unable to sleep. Further discussions revealed that she had missed an assessment with psychiatric services.

Dad acknowledged he was drinking heavily to deal with the situation, he explained that he also had sleep apnoeas and was overweight. Further discussions identified that they were experiencing stress as parents and the children had, at a family discussion complained about their behaviour. Since then, both parents had been making unsuccessful attempts to improve their behaviours.

I advised the mum that unless she got assistance there would be no improvement in the family’s stress levels. She agreed to self refer to her GP and seek assistance. Dad agreed to look at his alcohol consumption admitting that alcohol addiction was a feature in his family of origin, he also agreed that he did not take as much exercise as he used to. A plan was developed with the parents and family to address the issues identified in order to reduce the stress causing environments.

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I discussed other issues with the parents including: childcare, outings for mum and younger children, and counselling. I visited the family a week later to follow up on progress. Dad stated that the interventions we had identified were acceptable to both parents as it gave them practical options to help them. However, behaviour change is not easy but they were happy that they had spoken about their problems and we had agreed the actions they needed to take, they knew I was there to help.

I visited this family again recently. Mum had followed up with, and was now attending the psychiatric services for her regular appointments. Dad had made contact with the local Alcoholics Anonymous group as I had advised and is receiving support there. He is aware of the extent of his misuse of alcohol and plans to attend meetings.

The parents have become aware of taking more exercise and eating healthy foods and have slowly begun to lose weight; the children are also benefitting from this lifestyle change. They report that their sleeping pattern has also improved. With the help of the local Money Advice and Budgeting Service www.mabs.ie they report that they are managing their finances better. Mum’s mood has improved and I have mobilised local resources linking mum into a family morning play group for her smaller children when older children are at school, however the family still needs prompting to engage with preventive services and the younger children are often overdue routine vaccination.
Chapter 4
Green Wedge

The second wedge of interventions describes actions that are needed to connect cases (patients) that require health and social care resources to resolve the identified problems or concerns. These interventions include 1) referral and follow-up 2) case management and 3) delegated functions.20

1) Referral and follow-up in the Intervention Wheel identified a referral from a bartender of a local tavern about a customer who he suspected needed follow up for incontinence. In the Irish context, the nurse describes the admission and follow-up of a patient into her community caseload following referral from acute services and the ongoing referrals she identified and processed within primary care.

2) The American PHN described the case management of a mum and her overweight infant whilst Irish nurses provide an example of case management with a family of a seriously ill child in the home setting.

3) An example of delegated functions in the American context sees the nurse entrusted with the screening of all potential contacts following confirmation of a case of active infectious tuberculosis. The Irish example identifies the nurse as an educator in the home, other examples include; managing nurse led wound care clinics and immunisation clinics.

Figure 6: Intervention Wheel / The Green Wedge
Referral & Follow Up

Assists individuals, families, groups, organizations, and communities to utilize necessary resources in order to prevent or resolve problems or concerns21.

This story relates to the care management of Mary, a 74 year old lady, who fell at home and sustained a fractured neck of femur and was admitted to hospital for surgery. As part of the discharge plan initiative, the hospital nurses contacted me, the area PHN the day after Mary’s operation. The discharge planning initiative was developed with the input of hospital nurses and public health nursing as part of the National Discharge Planning Policy22.

This was Mary’s first contact with the public health nursing service. She had recently moved to the area to live with her sister, as her husband had died during the past 12 months. She was registered with the local GP but had not registered with the public health nurse. During Mary’s recovery, the ward staff and I liaised regarding the discharge plan. A multi disciplinary team was arranged and was attended by Mary, her sister, the ward nurses and members of the ward team, the members of the primary care team (PHN, physiotherapist, occupational therapist) and the hospital bed manager.

I completed a Common Summary Assessment Form; this is a standard assessment record and identifies all of Mary’s needs (physical, psychological and social). It is an assessment instrument used by PHNs to request care packages which include home help and/or other support services as required. I identified a need for supports including nursing, physiotherapy and occupational therapy.

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With Mary’s consent a package of care was planned to facilitate her discharge back to her sister’s house. The home help service was required to assist and support her sister, in her role as carer, to assist with Mary’s personal care needs. I referred Mary to day care services, physiotherapy and occupational therapy. These services facilitated Mary’s rehabilitation; the day care service provided respite for her sister from an otherwise full-time caring role.

As part of the discharging planning process, I ordered essential nursing equipment from community services including: a pressure relieving mattress and a cushion; subsequently delivered directly to Mary’s home. The plan of care was implemented and monitored to ensure it met Mary’s needs, to enable her to become independent again as her physical strength improved. This process took place in partnership with Mary, her family and the relevant health professionals.

There were a number of health promotion opportunities in this case. While there is no dedicated falls prevention programme in place in this area, a falls risk assessment tool was used and it identified Mary as a medium risk of falls. I identified that Mary was at risk of developing osteoporosis and I discussed the possibility of Mary having a diagnostic scan. I discussed this with Mary and encouraged her to speak to her GP.

This ongoing evaluation necessitated a number of visits to Mary at home. A special relationship builds between a PHN and a client and there is a space for concerns or needs to be voiced. In this case, I identified that Mary was anxious and she told me that she was finding life difficult since her husband’s death. With her consent, her case notes were forwarded to the primary care team for review. The GP agreed to discuss her mental health status with a view to making a referral to the primary care psychologist.
Case Management

Optimizes self-care capabilities of individuals and families and the capacity of systems and communities to coordinate and provide services.

Baby Leona was born at 37 weeks following an emergency caesarean section, arising from maternal placental abruption. Due to complications, Baby Leona suffered many physical problems and was nursed in a specialised paediatric unit.

Liaison with me, as the PHN, commenced soon after Baby Leona’s birth. I knew Baby Leona’s mother as I had visited her with her other children. The family lived on the edge of a rural town and her grandparents lived nearby. During my visits to Leona’s mum, I explained that I would have contact with the hospital’s paediatric unit liaison nurse regarding Leona’s care and plan for discharge home. I offered support and reassurance to the family and explained the steps involved preparing for Leona’s discharge.

Prior to the discharge I had co-ordinated the ordering of equipment and supplies from various community services and from the community pharmacy. I liaised with the other professionals involved in Leona’s care. Prior to discharge home a referral was made and accepted by the local early intervention team (the PHN is a member of this team). I initiated communication with Leona’s GP, whilst Leona was still in hospital.

In discussion with Leona’s family, an Assessment of Need form was completed. This identified a need to provide additional care for five nights per week to her family. The local health office funded additional care for three nights per week initially and after subsequent requests was increased to five nights per week.

An Assessment of Need form was reviewed in collaboration with the family and the multi disciplinary team ensuring care was sufficient to safely meet Leona, and her family’s, needs. I acted as an advocate and co-ordinator of this case with the parents. I involved my Assistant Director of Public Health Nursing who supported and requested additional nursing support for the family. I identified a need for home support to assist the family with practical household duties including getting siblings ready for school. This service was provided to the family.

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Leona’s care included managing naso-gastric feeding, oro-pharyngeal suctioning and ongoing physical therapy. Leona required care on a 24/7 basis as her risk of choking from secretions was very high. Leona’s parents had received training in the hospital to assist them to care for their daughter. The expert level of care they provided for their daughter must be acknowledged.

I recognised their fear and anxiety around the risk of preventing and managing Leona’s choking episodes. Her care plan was developed and reviewed frequently with her family. I liaised closely with the paediatric link nurse from the hospital and the GP. My role, in this case, was often educational, supportive, with attention to reducing risk and encouraging the family in their care of Leona. In conclusion it could be said that I partnered this family in the ‘case management’ of Leona.
Case Management

“Public health nurses (PHN), as part of primary care teams, are identified as “prime workers” with children at risk in the community as they visit every family with a new infant and then return, on a number of occasions, during the course of the child’s life. As part of their role within the multidisciplinary team, PHNs can refer directly to social work services and child protection services using nationally agreed standards”24.

Mary is a 28 year old woman with three children. Her last baby, Teresa, was born five months previously but was in hospital since birth due to a significant birth abnormality. Contact between myself as the PHN and the family commenced one week post delivery. As Mary was spending a significant part of her time in the hospital setting with Teresa, I completed Mary’s post natal checks at the hospital, facilitating Mary and her request to remain with her daughter.

I stayed in phone contact with Mary and visited her and Teresa in the special care baby unit. During this visit I liaised with the multidisciplinary team, ensuring continuous communication of Teresa’s progress. Teresa had required cardiac surgery and was being fed via nasal-gastric tube and required continuous oxygen therapy.

I visited Mary to discuss with her the preparations for Teresa’s discharge home from hospital. On arrival at the house, Mary’s sister (who I had met previously in the hospital) opened the door and invited me in. Mary and her husband were in her kitchen and so I walked towards them; at this time Mary’s husband came out of the kitchen and into the hallway to ask what I wanted. He appeared extremely angry and was swearing. I then noticed broken glass around the back door and red marks on Mary’s face and neck (she was in the kitchen but was facing me). Realising I had arrived into a potentially dangerous situation I attempted to diffuse it by talking to Paul whilst ensuring I had a clear exit strategy.

Mary’s other children then arrived home from school and their father took them upstairs to change out of their uniforms. It was when I was alone with Mary that she told me that her husband had attacked her and that he said he would hurt her again. I made my way to the exit saying that I had a number of things to clarify for Paul and Mary and would return at another date. I left the house and went directly to the Gardaí to report the incident and contacted the duty social worker.

My objective in dealing with this difficult situation was to ensure that I did not cause any further difficulties for Mary and to ensure that she and her children were not in immediate danger. The only way that I could achieve this was to ensure that I maintained a safe exit route enabling me to then report the incident to the relevant authorities for appropriate remedial action.

24 Senator Fidelma Healy Eames November 2011. Seanad Eireann Debate Vol. 211 No:11
The social team and Garda jointly dealt with the situation. Mary and her children were taken into safety. The social work department under took risk assessments of the family and then commenced an engagement process with her husband. I continued to visit Mary in the Women’s refuge and subsequently in her rented accommodation. I was able to provide support and education for her whilst she was caring for her baby with multiple medical needs.

My role, at a later date, was to support Mary in whatever decision she made and provide a link with other multi disciplinary services in a safe environment. In my role as the family PHN, I provide an account of the incident to the health board and in Court, where a safety order was granted. A safety order is an order of the court which prohibits the violent person from further violence or threats of violence. It does not oblige the person to leave the family home. If the person lives apart it prohibits them from watching or being near the home. Subsequently Mary and her children returned to the family home and her husband. The family remains together and the children remain on a child protection register.

I attend child protection conferences reviewing Mary’s situation and the child protection plan. I work with the family in the area of parenting skills, and in the education, support and medical management of Teresa’s needs. I also monitor Teresa’s developmental progress while linking with the multidisciplinary team.

Public health nurses work with families by using an ecological approach to identifying need, risk factors and issues of concern in order to prevent a child from crossing the threshold of significant harm. Everyone has a duty to protect children and the recent Children First: National Guidelines for the Protection and Welfare of Children (2011) strengthen arrangements for the protection of children. These guidelines provide a set of sound principles for good practice and emphasize the importance of inter-agency cooperation, outlining the various steps required in order to protect children at risk and to prevent the occurrence or reoccurrence of child abuse.

Delegated Functions

Direct care tasks a registered general nurse carries out under the authority of a health care practitioner as allowed by law. Delegated functions also include any direct care tasks a registered general nurse entrusts to other appropriate personnel to perform\(^{26}\).

I visit Tom, a 92 year old man, who lived alone with no local family supports. He was independent in caring for himself with the assistance of the home help service and meals on wheels service. He also attended the local day care centre twice a week. I had established these services to meet Tom’s needs. I ordered a personal safety alarm system and he uses this thereby reducing his anxiety about living alone and increases his confidence knowing there is support if he needs to contact someone.

Six months ago Tom’s physical condition started to deteriorate and he was no longer able to initiate walking unaided and quickly required the assistance of two people to help tend to many of his activities of living.

I carried out a nursing assessment of Tom’s capacity to continue to self care. This assessment established what was needed to help Tom to remain at home, as were his wishes. Of the many assessments carried out, Tom’s Waterlow\(^{27}\) pressure sore risk assessment tool scored medium risk. Based on this, a pressure relief mattress and cushion were ordered to provide protection for Tom against the development of pressure sores and to aid comfort.

When I identified his ability to transfer safely with one person was failing, I made a referral to community occupational therapist and, in conjunction with her a risk assessment was completed in relation to identifying safe transfers. The outcome was the need for a hoist during transfer.

A package of care was agreed in partnership with Tom. I met with each of Tom’s home help carers, as two carers were required to safely move Tom in his home. I identified that the carers required training in the use of the hoist and I arranged this for them.

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As the PHN responsible for Tom's care, I was delegating his personal care and assistance with other activities of daily living to home help carers. By working with each carer in Tom's home I demonstrated good nursing care with attention to: infection control, skin care and hygiene including the care of pressure areas and the importance of prevention, early identification and reporting of any deterioration in the condition of his skin. I taught by demonstration and assessed their ability by a process of 'Teach Back'. Once I was satisfied with their abilities I was confident that their care would be appropriate and that they would contact me if they had any concerns about Tom.

My PHN visits include re-assessment of Tom's condition and evaluation of the care plan. Tom is managing well at home, almost nine months later. Importantly Tom is very happy with his situation and admits that he was considering going into a long-term nursing home but he is delighted to be able to live in his own home. I am reassured that Tom receives safe and cost effective care and he is an excellent example of the benefit of a co-ordinated package of care.
Chapter 5
Blue Wedge

The interventions in this wedge aim, through a process of engagement and relationship building, to improve knowledge, attitudes, values, beliefs, behaviours and practices at all intervention levels in order to improve self-care management and build community capacity. The interventions are 1) health teaching 2) counselling and 3) consultation.

1) Health teaching examples in the American context includes teaching personal hygiene skills to students. The Irish examples identify the nurse providing antenatal classes, and teaching families age appropriate play for children. Other Irish examples include; breastfeeding support, infant massage classes, smoking cessation classes and nurse led enuresis clinics.

2) The American Wheel clearly distinguishes between counselling and psychotherapy, counselling is intended to clarify and facilitate problem solving. The American Wheel provides an example of bereavement counselling with a mum following the death of her infant. The Irish example describes counselling skills for post natal depression, and parenting issues. Other examples in the Irish context are; bereavement support, informal carer support, palliative care support and support to parents of children with special needs.

3) Consultation is demonstrated in the American Wheel when community leaders consult with a PHN about the effects of children witnessing violence in the home. The Irish examples identify the PHN consulting with Traveller women in relation to their perceived barriers to attending women’s health screening services. Other Irish examples include consultation with teachers, school liaison officers, community Garda, religious and voluntary organisations and key community activists.

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Figure 7: Intervention Wheel / The Blue Wedge
Health Teaching

Communicates facts, ideas, and skills that change knowledge, attitudes, values, beliefs, behaviours, and practices of individuals, families, systems, and/or communities. 

I teach antenatal classes to first-time mothers of all ages. I invite all mothers at the class to attend free infant massage sessions to encourage bonding with babies and help prevent social isolation.

Many are isolated and do not have an extended family living nearby to offer support in the transition to become an effective parent. A programme was developed by a local group called ‘Parents First’ to provide free infant massage while providing new mothers with outcomes of the skills to care for their children, an opportunity to make new friends and become part of the local community.

This first-time mothers group runs over a period of ten weeks. If other needs of mothers emerge during the sessions, they are then referred to a ‘Mother and Toddler’ group where further age-appropriate education is continued in order to provide suitable stimulation for effective parenting, child development and age-appropriate play. This programme can continue until a child starts pre-school, if there are needs perceived around parent-child interactions or appropriate parenting.

Programmes run in conjunction with the ‘Parents First’ group include: Building Blocks (to stimulate effective play), Conflict Resolution (to assist parents in dealing positively with conflict with children), Home management (to budget, cook healthy meals and organise their home successfully), Developing Positive self-esteem, Child Safety (resuscitation and first aid) and English for Foreigners.

Outcomes have identified:

- Peer support has become an unexpected bonus with mothers learning from other mothers
- Evaluations show reduced symptoms of post-natal depression
- The education element is insidious and the whole experience has been perceived as worthwhile by the parents attending
- It has proved very popular with parents self-referring to the group as well as being referred from social work and other agencies.
- In the right environment good parenting can be "taught"
Health Teaching

A group of Volunteers who were visiting vulnerable families were having difficulties in what they should be doing to stimulate age appropriate play.

The group consisted of 15 women, from various socio-economic groups and various ages who were visiting families and, offering personal support to mums and showed them how to play and stimulate their children. In some families the children were awaiting other services for example speech and language or play therapy.

The co-ordinator approached me to provide a teaching session. A service to visit families was established by a PHN over ten years ago. Volunteers are trained and Garda-vetted (clearance is needed, for certain prospective employees who have substantial unsupervised access to children and vulnerable adults, from Ireland’s National Police Service www.garda.ie) and provide support to parents. The original programme has been adopted and changed to meet emerging needs in the community. In the past year, for example, the organisation offered support to parents of children with disabilities from birth. The volunteers manage two counties and visit 24 families per month. The PHN facilitates health teaching to volunteers who visit outreach families.

In preparation for my teaching sessions, I obtained books entitled Caring for your Child for 0-6months, 6months -2years and 2 years to five years for each volunteer as a reference guide to check what is within normal development. There is a list of age appropriate activities used with a screening tool in the health centre to give parents. A copy of all the activities was given to each person. The volunteers modelled the skills required for each play activity for mothers to show the required interactions. The intention was that the mums would copy the interaction.

On my arrival I began with an introduction of myself to the group and introduced the topic of age appropriate play. I opened the floor to the women and asked if there was a particular area that they wanted addressed. Feedback from this discussion was noted on a flip chart. Examples of effective play were then discussed.

The group then went through one of the activity sheets and we came up with ideas on implementing games. As a result of these discussions the women made Zip Lock bags with Cheerios and wool for children to play with. This would allow the children to develop their fine motor skills while they were on waiting lists for interventions. All the women participated and we covered all the topics on our “Flip-Chart”.

31 HSE (2005) Caring for your Child www.hse.ie
Counselling

Establishes an interpersonal relationship with a community, system, family or individual intended to increase or enhance their capacity for self-care and coping. Counselling engages the community, system, family, or individual at an emotional level.\(^{32}\)

A PHN visits all women in the post natal period after discharge from hospital. On a recent visit I called to a home to undertake a birth notification visit and noticed that there was no partner present in the home. This would not be usual for the community I was visiting. During my visit, a number of issues came to light.

The ‘Wholly’ questions\(^{33}\) elicited that mum was depressed. She started to cry as she had no money and had left her home in fear of her partner. The baby was four days old. I tried to support her and together we made a plan, based on what she told me, to achieve a healthy safe environment where she and all her children were safe. I advocated on her behalf and mobilised the community resources available.

She has literacy problems and was unaware of her rights and entitlements. I advised her to visit the community welfare officer as she could access financial benefits and entitlements. I also advised her to contact the social work department in relation to supporting her and her family in relation to her partner’s behaviour.

I visited the following day and provided forms for a number of benefits she could obtain (and assisted with completion) and I arranged to see her weekly at the health centre. I directed her to services for victims of abuse and drew a map of how to get to the local counselling services, with pictures of how to get there.

During her visits to the health centre we managed and resolved some difficulties including her anaemia, stopping use of bottles with her four year old child and encouraging her to get the child to drink from a cup. After two weeks of trying her 4 year old child was drinking out of a cup.

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I followed up with Mum during a three month developmental check, she had attended the community welfare officer and obtained child safety equipment. She told me she had gone to counselling, was on medication and had arranged a legal order prohibiting her partner from contact for a two-year period.

She thanked me as she said for the first time she was not afraid or sad. She was independent and feeling well. She still appeared to be clinically anaemic so I advised her to go to general practitioner for a check up.

I will continue to be available to this mother. A PHN open clinic is available daily in the health centre from 9.30-10.30am. I will follow up to see if she will consider attending a family support programme.
Consultation

Seeks information and generates optional solutions to perceived problems or issues through interactive problem solving with a community, system, family, or individual. The community, system, family or individual selects and acts on the option best meeting the circumstances34.

While working as the designated Public Health Nurse for Travellers it became apparent from analysis of the customised assessment files (Harte & Marteinsson, 2007) that females in this population did not attend for smear tests. A factor I identified was the cost of fifty euro and the test was not covered by medical card.35

I brought information on screening uptake to the local Traveller Health Unit and finance was sought. Traveller women have higher parity, greater morbidity and mortality than the settled community36.

It was decided to undertake focus groups, facilitated by two researchers, to consult with the Traveller women to identify their perceived barriers to screening. The meetings were held during two ‘coffee mornings’ in the local Traveller organisations in the two counties. The stakeholders within the health services including the GP and primary care team analysed the information from focus groups. Among the concerns raised included a need for female smear takers, a lack of discussion with the women about cervical smears and the cost (Marteinsson, 2006).37 38

Outcome: The women had a choice to go to a female GP or their own GP. The cost of smears was met by the local health office. One women who never had a smear test before had abnormal cells detected. This changed the attitude and knowledge among the extended women’s relatives who all attended for cervical screening.

35 Screening is now free through a National Cervical Screening Programme. www.cervicalcheck.ie
36 Department of Health and Children (2010) All Ireland Traveller Health Study (AITHS): Our Geels, School of Public Health, Physiotherapy and Population Science, University College Dublin
The interventions in this wedge demonstrate collective action and require core skills of communication and networking. The geographically based PHN is ideally suited to these actions as she is known in the local community, has a presence and a good knowledge of the community dynamic. Overtime, the PHN builds trusting relationships with key community stakeholders and many Irish PHNs are members of local community and parish groups. The interventions in this wedge are 1) collaboration 2) coalition building and 3) community organising.

1) Collaboration in the American Intervention Wheel reduced barriers to health care for American Indian people living off reservation, the Irish example shows how a community mother’s programme collaborated with a statutory health agency to provide a parenting skills programme for first time mothers. Other Irish examples are collaboration across statutory and non-statutory agencies such as: Barnardos, the Alzheimer’s Association, St. Vincent de Paul.

2) Coalition Building is explained in the American context of improving breastfeeding rates which resulted in a coalition between PHNs and maternity nurses at a local maternity hospital. The Irish example tells of a coalition between professionals and volunteer mothers who provide a supportive parenting resource to local families. Other Irish examples include coalition building with community groups such as Meals on Wheels.

3) Community organising in the American context is shown when a PHN forms a partnership with other community groups to develop a plan to address alcohol use in the community. The Irish example below details how the Community Mother’s programme empowered communities to organise their own parent and toddler groups. Other Irish examples see PHNs working with active retirement groups and social inclusion agencies to access resources and links to statutory services to organise transport, health promotion and funding.
Figure 8: Intervention Wheel / The Orange Wedge
Collaboration

Collaboration between the Health Service Executive (formerly the Eastern Health Board) and the Bernard van Leer Foundation enabled the development of the Community Mothers Programme\(^{41}\). The programme has been running since the 1980s in order to aid the development of parenting skills among first-time parents, mainly in areas that experience socio-economic disadvantage.

Set up in the recessionary times. The programme has found a cost-effective method of providing one-to-one support, with volunteers taking the place of nurses in community outreach. Many early childhood programmes use home visiting as a strategy; in the Community Mothers Programme it is the strategy\(^{42}\). The Community Mothers (CMs) are all women from the community who volunteer to visit first-time parents in their homes, once a month for one hour over a twelve month period.

It is based on the belief that more experienced parents are in a unique position to provide skilled help to families. In the greater Dublin area, which includes rural as well as urban communities, around 150 volunteer CMs provide support to around 2,000 parents each year. The programme is offered to all first-time parents; choosing to participate or not, it is up to them. In many neighbourhoods in Dublin, over 90 per cent sign up. In 2011, 55 per cent of women who enrolled in the programme were lone parents and four per cent were teenagers\(^{43}\).

The support is highly-structured and provided chiefly through monthly meetings of the CMs with the parents in their own home during the first year of their babies lives. The visits focus on healthcare, nutrition and overall child development, while recognising that parents know their children best and want to do their best for them. The one-to-one support is sometimes complemented by group sessions.

Volunteers in a Professional Structure

The aim of the programme is to aid the development of parenting skills and enhance confidence, self-esteem and parenting practices among the parents supported. The CMs also benefit, as the programme is based on models usually implemented by professionals and they are recruited trained and supported by the nine Family Development Nurses who work with the programme. The Programme Director guides the work of the Family Development Nurses.

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\(^{43}\) Community Mothers Programme (2011) Annual Report Dublin: Community Mothers Programme
The CMs have an added advantage however in that they have already formed relationships within their communities. One of the main challenges for the CMs, therefore, is to avoid professionalising, as this can have a negative effect on their relationship with the parents and their communities. Some CMs have stayed with the programme for many years, while others work for only a few years before leaving, either to work professionally in community support services or to use their experience and skills in their own family environment. It is not unusual for mothers who have received the programme to go on to become CMs themselves.

An ‘Empowerment’ Model: Providing Non-Prescriptive Support

The approach is non-prescriptive and supportive of the parents’ own ideas. During the monthly meetings, the CMs discuss with parents any problems they are experiencing, as well as general childrearing issues, encouraging them to find their own solutions and allowing them to set themselves targets for achievement by the following meeting. This helps to build and maintain trust between the CMs and the parents and communities they work with. The CMs also give the parents some health information and parenting educational teaching tools produced by the CMs Programme. These materials serve to enhance the work of those who present the programme.

An evaluation study in 1989 when babies were one year old showed favourable outcomes for the programme families, when compared with the control families, in areas such as maternal self-esteem, maternal and child nutrition, developmental stimulation, maternal morale and well-being, and immunisation. Seven years later, when the children were aged eight, a follow-up study traced one-third of the families from the 1989 study. A major finding was the persistence of superior parenting skills among the programme families. Children whose mothers had been in the programme were more likely to read books, to visit the library regularly and, to have better nutritional intake. Mothers had higher levels of self-esteem. They were also more likely to oppose smacking, to have developed strategies to help them and their children deal with conflict, to enjoy participating in their children’s games, to have better nutritional intake, and to express positive feelings about motherhood. This evaluation was carried out by the Health Information Unit of the Health Service Executive (formerly the Eastern Health Board) in collaboration with the Community Mothers Programme and the Department of Public Health Medicine and Epidemiology at University College Dublin.

In conclusion, collaboration between the Health Service Executive and the Bernard Van Leer Foundation has enhanced the capacity of the Community Mothers to enable parents to maximise their role and in doing so, help children to reach their full potential.

Coalition Building

Coalition building promotes and develops alliances among organizations or constituencies for a common purpose. It builds linkages, solves problems and/or enhances local leadership to address health concerns.47

The Community Mothers Programme is dependent on the coalition of groups of professional nurses and volunteer mothers, known as Community Mothers (CMs) who provide a non-prescriptive and supportive parenting resource to local families.

The Programme Director who has experience of both the professional and the community empowerment model of family support, identified the need and advocated for leadership to build linkages between statutory and voluntary services in the community to provide dedicated support to new mothers. The Programme Director is employed by the Health Service Executive and is responsible for recruiting, providing training and directing the Family Development Nurses (FDNs) in their work with CMs.

The benefits of recruiting FDNs from the local public health nursing service is; their professional nursing background, their experience of working with families in local communities and their links to public health nurse colleagues working within local communities who are often instrumental in referring mothers who may be suitable to work as CMs, to the FDN.

The benefits of recruiting volunteer mothers from the local community is that they have experience of being a parent in this community, have formed relationships within their communities and therefore understand the community dynamics and the culture of the local neighbourhood. Many of the mothers who have received the Programme go on to become CMs themselves, providing a cascade effect.

A coalition between these two groups provides shared learning and an ecological approach to the community development model which recognises that parents know their children best and want to do their best for them.

Community Mothers fill out a report on each visit which forms the basis for the discussion with the FDN. In the case of each baby, the FDN would give the CM new material to guide her visits over the following month. Each CM carries out in the region of five to fifteen visits in a month.

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**Feedback from Programme members**

**Programme Parent**

When I first came home from hospital with my first-born Tara, I have to say that I was shell shocked, delighted and frankly a bit nervous about what lay ahead. The Public Health Nurse asked me would I be interested in meeting a mother from the local community who would visit me to give me some tips and helpful guidance. I agreed, and a lady called Bernie came to visit me. She gave me information leaflets that helped me with Tara’s development. She also informed me about what was on in the local community.

**Community Mother**

I am very surprised now at how rewarding it is. I have met new mothers from various countries and backgrounds and all with different issues. Yet, all of us have one thing in common—we’re all mothers! You receive great satisfaction when you return to visit a mother who has tried something that you suggested and it has helped her or her baby. That acknowledging smile and thank you makes it all so worthwhile to be in a voluntary position like this during these times.

**Family Development Nurse**

My role as FDN is to find, interview, recruit and train CMs to visit first time parents in the community providing support and a flexible set of strategies to meet the programmes aim. Although I am a public health nurse by background clinical nursing duties are not part of my FDN role. I can have up to eighteen CMs in my charge at any one time making visits to a cohort of 120 mothers. I provide support to these CMs and am available to discuss problems and developments in relation to the programme. Once a month I meet with each CM to discuss the families she visits, I also meet the CMs together every six weeks for group support and training.
Much of my time is spent engaging with women and families in the community, finding mothers who might be suitable to volunteer for the role of CM and inviting parents to join the programme. Making links and networking with other community organisations is also a key part of my role. I think the most rewarding aspect is seeing confidence increase in parents who are visited by the CMs enabling them to become more connected with their own community and more capable of understanding the rationale for the parenting strategies that they have chosen.

**Programme Director**

The development of the Community Mothers Programme in a geographical area takes approximately 18 months. It is my role as Programme Director to provide overall support, education and management in the implementation, maintenance and development of programmes. I am responsible for developing the systems and processes which support the FDNs to prioritise and direct their efforts to fulfil the programme objectives. On a day to day basis, I assist the FDNs to engage with their CMs in a process of mutual learning.

Coordinating the programme areas and facilitating teams to solve their own problems by bringing them together on a regular basis is another aspect of my leadership role. Facilitating undergraduate and postgraduate student nursing placements and championing individual FDNs and CMs who show potential for future leadership roles in the organisation and community further reflects the community development philosophy of the programme.

Fostering links with a wide range of statutory and non-statutory agencies and key community personnel supports this work and ensures that the programme materials continue to be culturally relevant and appropriate. Programme evaluation and report writing is another component of my role which helps clarify goals and supports planning and budget allocation.

Although the role of Programme Director has presented many challenges and learning opportunities for me over the years, I gain great satisfaction from knowing that the Programme has made a positive contribution to the lives of all those who have participated in the programme; parents, children, volunteers and professionals.
Coalition Building

Post natal support was identified as a need in one local area for mum’s experiencing some distress or finding it difficult to cope since the birth of their baby. The public health nurse (PHN) made contact with the community co-facilitator (an employee of the local community resource centre which is a non-statutory agency providing services within the community) to discuss a coherent response to this need. Together they agreed that the most cost effective and sustainable response would be achieved by forming an alliance between the statutory and non-statutory agencies in the local community.

The community resource centre which is funded by a wide variety of organisations including the HSE and Dublin City Council, was identified as the most suitable location to host the post-natal support groups and to make use of the skill set of the staff members which are; group facilitation, group learning and childcare.

As a result of this coalition, a post-natal support group was developed which provides a forum for postnatal mothers in distress or experiencing symptoms of postnatal depression to meet, talk, be listened to, and develop effective coping strategies and support for themselves. This group meets weekly for a total of eight sessions in the centre and a new group forms each school term. Mothers from any part of Dublin may self-refer or be referred by any health professional. The shared statutory and voluntary organisation leadership promotes positive community relationships. The main facilitator can be recruited from a nursing or social care background that has additional formal counselling training already undertaken.

The group is advertised on Parentline, in health centres, chemists, post offices, to GP practices in the local area and on the www.rollercoaster.ie website. Promotion of the group is made to a wide variety of health professionals in the maternity hospitals and in the community to include PHNs, midwives, mental health nurses, GPs, Practice Nurses, and Social Workers.

The coalition has provided for integration of skills to achieve maximum effectiveness allowing the PHN facilitator to work with others who have valuable skills outside the world of nursing or social work. This brings an extra quality to the group and allows both partners to learn from each other. The group integrates mothers from different nationalities and socio-economic groupings. The common sharing of feelings of maternal distress and the ready support from other group participants allows mothers to develop an appreciation of all people in their group. The group validates mother’s feelings, enables mothers to talk to others and empowers mothers towards self-help using a cognitive behavioural approach.
Each mother is asked to evaluate the programme at the end of the 8-week session. A questionnaire is provided and a stamped addressed envelope and mums can complete the evaluation at the end of the sessions or return it in the post. Mothers have favourably evaluated the group with such comments as:

‘I feel more like myself again.’

‘Learned how to deal with worries’

‘Made new friends’

The facilitators in their follow up found that mothers who have experienced the group are more likely to continue to source further programmes of self-improvement for themselves either from the same resource centre or in their own locality. The group is efficient as it makes effective use of staff and venue resources without additional costs to the local health office or the resource centre.

The group is the only known group of its kind in the Dublin area, there is a need for coalition building between community agencies in other regions to provide a customised resource for mothers who are experiencing post-natal distress.
Community Organising

Helps community groups to identify common problems or goals, mobilize resources, and develop and implement strategies for reaching the goals they collectively have set.

Community Mothers Programme

The Community Mothers (CMs) by adopting a philosophy of empowerment has overcome obstacles to the realisation of the needs and desires of their communities and many of the CMs have become leaders themselves. The initial work of the programme which identified and developed a response to the expressed needs of parents within communities, embraced a model of empowerment.

Parent and Toddler Groups

Once a process of empowerment begins it then appears to develop a momentum in other directions. As a result of this empowerment parent and toddler groups have developed in some areas as a spin-off from the Community Mothers Programme. These groups are organised by the community. CMs and parents are involved in the planning and organisation of the groups and activities are built around the needs of the children.

The groups are held in community centres and schools where they can link up with the Early Start Programme. The groups provide opportunities to learn about parenting from other parents reduce social isolation and enhance parent child bonds. A number of the Family Development Nurses take the opportunity to promote healthy lifestyles in these groups and consider the input of the local public health nursing team as a valuable resource.

Local Parent and Toddler Group

Our local parent and toddler group meet every Tuesday morning in a local girls’ school. We have been in existence for over twenty years and some of our original parents are coming back to us with their grandchildren.

We have, on average, twenty-five parents or carers attending each week and over thirty children. We organise a range of activities that include painting, play dough, drawing and gluing. We also do seasonal crafts for occasions such as Christmas, Easter and Mother’s day. At each session we give the children sandwiches and fruit for their lunch while the adults can have tea or coffee. The sessions then end with some action songs, which the children love.

During the year we had two visits by the Public Health Nurse. She brought information on children’s health issues and also about how to look after their teeth. The sessions were very informative and there was a lot of sharing of experiences.

Both parents and children love coming to the group. They always say how much they miss it when the school is closed. It is a great source of friendship and support for people trying to rear their children at this difficult time. One of the parents wrote this in our comment book: “The group gives mothers, especially first-time mums, a chance to meet other mums and exchange tips to support each other. It also gives all of us a place that is community-based and not miles away from home where we can bring the kids. I would be lost without it”
Chapter 7
Yellow Wedge

The interventions of this wedge impact health care at a societal level, providing a voice for the needs of individuals, families and communities and acting from a marketing model to influence individual / family and community behaviours and practices whilst developing and enforcing relevant health and social care policies. The interventions include 1) advocacy 2) social marketing 3) policy development and enforcement.

1) The American PHN advocates on behalf of a family with active tuberculosis, the Irish example sees the PHN advocating on behalf of Travellers in primary health care. Other Irish examples include identifying and responding to needs for interpretive services for migrant families, needs for social welfare entitlements and access to acute care services.

2) Social marketing in the American example creates a marketing campaign in response to the identified health problem of obesity. Irish PHNs undertake a needs analysis for a parent and infant group and follow this up with a marketing plan to fund and provide services. Other Irish examples include: advertising in parish newsletters and local media for parenting and smoking cessation programmes, applying for sponsorship from private agencies.

3) Policy development and enforcement in the American context sees the nurse enforcing environmental health policies. Policy development and enforcement in the Irish context relates to clinical governance in relation to community newborn blood spot screening blood. Other Irish examples include representation of PHNs on national and regional steering groups for policy and guideline development and implementation, for example, wound management guidelines.

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Figure 9: Intervention Wheel / The Yellow Wedge
Advocacy

"Pleads someone’s cause or acts on someone’s behalf, with a focus on developing the capacity of the community, system, individual / family, or family to plead their own cause or act on their own behalf”\(^{51}\)

Primary Healthcare for Traveller Projects

Irish Travellers are a nomadic Irish ethnic group defined as ‘the community of people who are commonly called Travellers and who are identified (both by themselves and others) as people with a shared history, culture and traditions including historically, a nomadic way of life on the island of Ireland’\(^{52}\). Public health nurses (PHNs) day to day work with the Irish Travelling community includes pleading the case for targeted health services such as, dental services for traveller children and environmental services e.g. improved waste management, running water and electricity for traveller halting sites, in response to the issues identified from community assessment.

Successful outcomes from PHN intervention have provided women’s health screening for traveller women, targeted follow up clinics for issues identified from the PHN childhood screening programme, and ‘catch all’ immunisation clinics to address low childhood immunisation rates. As part of this continuing advocacy role PHNs facilitated and were acknowledged for their work in the collection of health information for a national study into the status of traveller health which builds on previous work identifying the poor life expectancy of Irish Travellers, traveller women live 12 years less than settled women and traveller men 10 years less than settled men\(^{53}\).


\(^{53}\) Department of Health and Children (2010) All Ireland Traveller Health Study (AITHS): Our Geels, School of Public Health, Physiotherapy and Population Science, University College Dublin
To respond to these identified health inequities a primary health care project for Travellers was developed in 1990 through a collaboration with Pavee Point, the National Traveller Organisation which is a government-funded non-governmental organization (www.paveepoint.ie) and the then Eastern Health Board. A Director of Public Health Nursing has been involved since the design stage and the project which was established as a pilot in Dublin was fully implemented by 1994.

A PHN was appointed as the primary health care lead alongside a community development health professional, the community health professional has a background in social science and is employed by Pavee Point. Following recommendations within the National Traveller Health Strategy54 other similar projects were developed nationally which endorsed the primary care approach and which have developed the capacity of Travellers to act on their own behalf.

The initial aim of the project was to deliver peer led primary health care programmes for Travellers by traveller women. The PHN allocated to the project advocated for the educational and other resources needed to support these women in their new role. Traveller women, through a process of personal development including literacy, acquisition of knowledge in relation to community development and empowerment, learned how to promote health and wellness amongst their own communities. Traveller women are employed in various areas around the country to facilitate peer led primary health care in coalition with PHNs and other health and social care providers both statutory and voluntary.

The programmes provided include; women’s and men’s health screening, immunisation, antenatal care, post natal care, child safety at caravan sites, water safety, car safety, drugs and alcohol advice, mental health and wellness, healthy aging and any other programmes requested by the participants. Recent programmes have included sexual health for teenagers and the “cook-it” program for both children and adults. Both of these programmes have been well attended and also included some of the children’s friends from the settled community. The Traveller health care workers and the PHN take the responsibility for issuing public health alerts as notified including Measles and H1N1 influenza outbreak.

The employment of traveller women supports continuity of care for Travellers who have been discharged from acute services ensuring that links are in place to plan a successful discharge. The Traveller women have become a valuable resource from whom local Traveller groups seek advice and who can facilitate service follow up providing advocacy if needed. Representing travellers at local accommodation offices and committees are further aspects of the traveller women’s own advocacy role. The Traveller women have gone on to provide cultural awareness programmes across service providers promoting an increased awareness of the traveller culture amongst these service groups.

Arising from the input from the Primary Healthcare Traveller Project and the collaboration with the PHN service the health of the women and children of the Traveller population in those areas with projects has improved significantly. However travellers continue to have significantly higher mortality rates than people in the general population and deaths from respiratory and cardiovascular disease and from suicide are more markedly increased in Travellers compared to the general population. At the launch of the AITHS report, Ms Mary Harney, the then Minister for Health accredited the marked improvement of Travellers health to the PHNs involved in these projects.

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55 Department of Health and Children (2010) All Ireland Traveller Health Study (AITHS). Our Geels, School of Public Health, Physiotherapy and Population Science, University College Dublin
56 Department of Health and Children (2010) All Ireland Traveller Health Study (AITHS). Our Geels, School of Public Health, Physiotherapy and Population Science, University College Dublin
Social Marketing

Uses commercial marketing principles and technologies for programs designed to influence the knowledge, attitudes, values, belief, behaviours and practices of the population of interest57

Public health nurses (PHNs) based in a Dublin health centre identified the need to provide a support group for new parents in the area. The PHNs had profiled this area to estimate the nature and extent of the social need and to plan realistic responses which would benefit the local community.

The population within the geographic catchment of the health centre is approximately 42,000 persons including a large mixed ethnic population. The birth rate for this population cohort is approximately 1,500 new births per year. Common issues identified by mothers at public health nurse home visits and clinic service contacts are; feeding and weaning problems, sleeping issues, rashes, low immunisations rates, and infant being “a little bit off”. One of the most important facts learnt by PHNs from their discussion with young parents in this relatively new large suburban area was that there is little ‘sense of community’ amongst the young parent population.

A planning and development group was then formed by the PHNs to address the issues identified. The PHN group priced local amenities and estimated that funding of €700 would be required to hire a room in the local community centre annually. The group then applied for and acquired part funding of €500 from the Local Area Community Partnership Group. The group agreed to request a contribution of €2 per week per parent to meet the €200 deficit but this is not a mandatory contribution.

All PHNs in this geographical area were requested to inform each new mother they visited about the new Parent and Infant Group and to issue them with the advertising flyer. The Parent and Infant Group is advertised in the local newsletter and flyers are placed in local amenities and local health centres.

A flexible parent and infant programme was developed by the group. An evaluation process was built into the programme to facilitate quality assurance and to ensure the inclusion of parents in the planning for the future of this group. A start date was identified and the group met with other PHNs in the geographical area to further advertise the proposed programme.

The group sessions consists of 10 to 16 parents who attend on a weekly basis. Parents and infants can attend from two week’s post natal and continue up to twelve weeks post natal.

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Facilitation of this group commenced in March 2012 and the Programme encompasses the following group sessions;

- Baby massage classes facilitated by a baby massage therapist
- Feeding and weaning of infants and children
- Infant child health screening
- Safety in the home and other environments
- The importance of play
- The importance of books and visual prompts
- Swimming for infants
- Positive mental health and wellbeing for parents
- Positive parenting

Outcomes from the evaluation of the programme by new parents are very positive and include comments such as:

- “I made friends”
- “Arranged to socialise outside of the group thereby reducing sense of isolation”
- “Great sense of community”
- “Very good programme – would not change a thing”
- “Facilitators extremely helpful”
- “Sharing of information”
- “Supportive to me as a new parent”

The prime need of this young suburban area was for parents to get to know each other, to have a place to meet, to increase their knowledge base and to feel connected. The PHNs invested valuable time in learning what these parents needed the most, they did not assume to know or to provide unsolicited services. Responding appropriately to the identified needs has positively influenced the behaviour of parents within the local community.
Policy Development and Enforcement

Policy development places health issues on decision-makers’ agendas, acquires a plan of resolution, and determines needed resources. Policy development results in laws, rules and regulation, ordinances, and policies. Policy enforcement compels others to comply with the laws, rules, regulation, ordinances, and policies created in conjunction with policy development.

The Irish PHN has significant responsibility at the individual and systems level of practice for newborn blood spot screening (NBS) to ensure the health of the population in inherited metabolic disorders. In 1966 a National New-born Screening Programme for Phenylketonuria was established in Ireland. It was among the first national programme of this kind in the world.

Phenylketonuria is common in the Irish population with an incidence of 1:4,500. Other newborn screens have been added overtime such as Galactosaemia as it is particularly common in the Irish Traveller population with an incidence of 1 in 450 births in comparison to 1 in 36,000 births in the non-Traveller population. Screening for Cystic Fibrosis which is the most common genetically inherited disease in Ireland is the most recent screening test to be included in the NBS. Ireland has the highest proportion of people with Cystic Fibrosis in the world, with almost 3 in every 10,000 people in Ireland having the disease.

Early detection is crucial and may save the child’s life, protect the child’s cognitive function and facilitate optimal health outcomes through early diagnosis and management. NBS is offered to all parents on behalf of their child, parental consent is required to carry out this screen and parents have the right to opt-out of screening. Timely and appropriate health information needs to be provided to all parents to support them in their decision making.

Prior to the practice of early hospital discharge of mother and infant from maternity services, the responsibility for the NBS lay solely with the hospital / midwife. However in recent years mothers and infants may be discharged within 24-48 hours post delivery and in such instances the PHN service is responsible for undertaking the NBS. There is evidence in one region that 43% of all births notified have NBS undertaken by the PHN service.

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60. Information accessed from Cystic Fibrosis Ireland www.cfireland.ie


This systems level change requires effective liaison between the hospitals and the community areas. The Director of Public Health Nursing is now responsible for ensuring that the NBS is offered to and completed within the agreed timeframe on all infants who are discharged home prior to having NBS undertaken. Community NBS is now routinely included in family health interventions offered by the PHN service.

Overtime difficulties reported by PHNs in implementing this intervention to a quality standard included difficulties with accessing families, completing the screen within the timeframe and ensuring safe carriage. These are recorded in a review of the service and are listed as:

- Location of migrant groups
- Failure to receive a safe and timely request for the NBS
- Insufficient information on the Newborn Screening Card
- Insufficient time between sample taking and postage to allow complete drying of sample
- Absence of weekend postal service leading to time delays in dispatch of samples
- Cross border births and differing protocols i.e. Northern Ireland and Republic of Ireland borders
- Informing parents regarding the need for repeat testing and the test in general

Identification of these issues and concerns PHNs had about absence of screen results for parents and how to address parental concerns when a repeat test is required, ensured a place for PHNs on the National Advisory Group which revised the policy for NBS. Regional governance groups which included PHN representation were devised to oversee the implementation and enforcement of the new programme. Changes to the NBS included the development of an information pack for parents, a change in the format of the sample collection card, acquisition of informed consent from the parent/guardian and the inclusion of a refusal process.

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Implementation and enforcement of the new national policy included the delivery of a training programme for all relevant nurses, ensuring a seamless delivery of the NBS programme across settings, identification of lead nursing staff in the hospital and in the community who are accountable for the NBS service from birth to test result reporting. The need to develop a national Standard Operating Procedure (SOP) and audit tool for the NBS was also identified at this time.

A national SOP is now in place to support nurses and other disciplines in the delivery of the national programme. The NBS card was revised following audit to improve accuracy of reporting. PHNs were consulted during the development and audit of the SOP and again as part of the audit recommending changes to the NBS card64.

Informed consent is obtained by PHNs when collecting the NBS sample in the community setting. A copy of the consent is kept by the PHN who also has responsibility for posting the blood sample in a registered envelope to the national laboratory. The PHN will use her persuasive skills to dissuade any refusal and will communicate evidence based information to the parent as to the importance of availing of the test. In the rare event of a refusal, the PHN implements the refusal process as outlined in the SOP and reports the refusal to the relevant agencies. The PHN provides the parent with her contact details in the event that the parent might change their mind and agree to the test later.

Systems level changes which impact the PHN service and which were made following policy enforcement include:

- Dedicated PHN lead identified accountable for the programme in the health service area
- A new NBS register in each health service area which is maintained by the Assistant Director of Public Health Nursing

Other systems level changes which have yet to be addressed include the development of information technology to support the collection of NBS data and the issuing of interval reports from the National Laboratory for cross checking with both the Birth and the NBS registers to ensure that all infants are offered / in receipt of this important screening service.

64 Health Service Executive (2011) A Practical Guide to Newborn Bloodspot Screening in Ireland www.hse.ie
Conclusion

This first Irish report has provided a range of examples from public health nursing practice using the template of the American Intervention Wheel\textsuperscript{65}. The examples clearly identify the scope of the role of public health nurses working for the health of the population in Ireland. A common theme throughout the stories is the depth of relationships built, over time and on a foundation of trust, between nurses and their patients within families and communities.

Issues that restricted the PHIG group when accessing and selecting stories for publication were the lack of time nurses had in their day to day work to adapt stories and the risks to revealing patient identity. Despite making stories anonymous, the uniqueness of the story and the nature of the nurse patient relationship within which the wider determinants are addressed may have risked revelation.

In the introduction to this report the American authors of the Intervention Wheel admit the similarities and subtle differences in the work of public health nurses in America and in Ireland. The PHIG group invested time discussing and understanding definitions from the American Intervention Wheel and the subtleties of the language used to describe interventions at each level before matching suitable stories. This was a valuable learning exercise which will support the work of future editions. Some of the examples provided record how interventions are implemented in practice rather than showcasing actual stories. Future editions will provide a platform for a range of stories from contemporary PHN practice guided by the information in this first publication.

The role of the public health nurse is essential within the healthcare system as it moves to further developing primary care and population based health outcomes. The visibility of the public health nurse role is important to ensure it is valued as an important member of the multi disciplinary team, improving health outcomes and identifying and improving local health needs.

Public health nurses have stories to tell that highlight the complexity and interconnectedness of their population health role, the American Intervention Wheel provides a comprehensive template for presenting these stories. It is hoped that this first collection of Irish stories will provide insight into the role of the Irish public health nurse for, the nursing profession, the multidisciplinary team in primary and integrated care, public health educational programmes, and, for policy makers.

The overall results of the Institute of Community Health, Population Health Interest Group, development work supports a governance framework for the collection of public health nursing service interventions and outcomes facilitating comparison of the public health nursing service nationally and internationally.

An interactive hub / website hosting stories from practice would enable public health nurses from different regions to share and learn from each other providing a rich resource for undergraduate and post-graduate nursing programmes and for the international development of the profession.

The selection of stories in this document, present Irish public health nursing interventions across individual/family, community and systems levels of practice. This document is not the end it is the beginning of the process. Further 'story telling' and work of both the PHIG and other key stakeholders is required to ensure that the work of 'carrying the bag' for public health nursing in Ireland and elsewhere remains visible and valid.
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