

REPORT TO BCCU

DEVELOPMENT OF SOUTHERN HEALTH BREAST CARE NURSE CARE COORDINATION SERVICE

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BACKGROUND

This paper describes the model developed for the first designated breast care nurse/cancer coordination services at Southern Health. Southern Health is the major provider of breast cancer services in the southern region of Melbourne. Each year 200 – 250 women newly diagnosed with breast cancer are treated, but prior to BSEP, cancer coordination and other breast care nurse (BCN) functions were provided haphazardly, and were mostly unpaid activities voluntarily undertaken by qualified breast care nurses in other positions. The absence of an existing formal role was only beneficial in that it enabled the project team to construct an ideal model for a breast care nurse service rather than change an existing system of care.

SERVICE SET-UP

Qualified and experienced breast care nurses (~3 EFT) were appointed to designated project positions in July 2000 with the intention that they work as a team in the region, across organisational, professional and clinical unit boundaries. Professional supervision and Breast care nurse team development activities were provided jointly by the breast services Nurse Unit Manager and a specially appointed social worker. Line accountability for the BCNs was to the Breast Services Nurse Unit Manager and the BreastCare Project manager. This proved useful for these project funded positions as it meant BCN matters were routinely raised at appropriate senior professional and administrative forums.

The Southern Health Breast Care Project was unique in adopting a 'nursing team' approach with some practice supervision and support coming from outside the nursing profession.

SERVICE MODEL IN PRACTICE

The necessary skills most helpful in the development of Breast care nurse roles were clearly available in several professional groups, however a social worker was considered the most appropriate appointment to develop and maintain a supportive working environment for the BCN team; to supervise their direct practice with women and enhance their counselling skills; to help explore the emotional and professional issues arising for BCNs in the course of their work, and to help the breast care nurses understand the organisation in terms of systems theory and organisational change.

These support, supervisory and organisational change aspects of the social work function helped the breast care nurses use their skills and experience to best effect. The skills of the social worker also enabled the BCNs to explore the personal impact of this often emotionally charged work. In summary this relationship helped maximise the BCNs capacity to help the women with whom they worked. It helped them deal more confidently and knowledgeably with role overlap with other professionals and it helped them consider, reflect and understand the impact of their somewhat unorthodox responsibilities as they followed women along an individual, woman-focussed treatment pathway which often involved several treatment teams in different organisations.

Inherent in this service model is clear acknowledgement of the well documented emotional toll on those undertaking care of people with cancer. The literature emphasises the value and importance of systematically offering support & clinical supervision to breast care nurses. The National Health and Medical Research Councils 1999 'Psychosocial Clinical Practice Guidelines', includes the recommendation to support health professionals exposed to the "grief, anger, frustration and resentment" which often accompanies women and their carers following

a breast cancer diagnosis. A study performed by the Victorian Centre for Nursing Practice Research also identified the need for the breast care nurses to have clinical supervision, “particularly those in dedicated roles” because they are working with a vulnerable, distressed and often demanding group of women.

Fortuitously, the strength and depth of the real partnership between the breast care nurse and the social worker was evident early. The social worker had a specific mandate to engage with the BCNs, not to just wait to be asked for input or support. Contacts between the breast care nurses and social worker involved regular, planned individual supervision sessions and focussed, team-based activities including case management discussions, community resource and referral advice, and more general problem solving. The social worker managed a very small caseload of clients on referral from the BCNs

A significant advantage in having the social worker engaged with the BCNs was her willingness and ability to speak authoritatively in support of BCN needs which often gave additional strength to the voice of the Nurse Unit Manager around project development matters, evaluation techniques, and in the design of work practice reviews. Time was respectfully set aside for the BCNs to raise and discuss clinical and general practice issues and time was also available to encourage personal reflection. It was helpful that a professional external to breast cancer nursing was involved in this supervision/reflection & review process as it made such activities clearly part of the BCNs “real work”, so effectively labelling them legitimate & valuable. The formality and legitimacy of such activities is still absent from many, perhaps most traditional nursing positions, even in many cancer care settings.

THE CARE COORDINATION FUNCTION – WHO OWNS IT?

In recent years much has been written about the various complex roles taken on by nurses in cancer care. The Southern Health Breast care nurse role descriptions were modelled on existing positions in other Victorian organisations and many of the BCN functions are also found in the position descriptions of nurses in a wide variety of fields. Breast care nurse position descriptions usually describe broad functions such as support, information provision, coordination of acute treatment and referral to other services. This group of activities can broadly be labelled care coordination.

Such care coordination is increasingly a function being undertaken by nurses, particularly in some community nursing roles and in positions involving transition between hospital and home although it remains a less common function inside the acute sector. However it is a function which increasingly takes centre stage when workplace efficiencies are demanded from clinical units dealing with complex health care. Such work efficiencies are routinely dependent on care being well coordinated ‘somehow’ and by ‘someone’. The idea that all patients will be able to manage their own often complex care arrangements when many staff barely understand anything outside the care provided by their own unit is absurd, and is increasingly being recognised as such. Care coordination, whilst not automatically the domain of one single professional group, *is* a function very appropriately undertaken by nurses.

Women with breast cancer move quite freely between public and private sectors, between inpatient and outpatient care and between numerous different health professionals for their primary care. To work successfully as a BCN in acute health requires a sophisticated understanding of health systems. Effective care coordination requires the BCN to move as freely as the woman across systems and places, and to have a good appreciation of the professional roles of the different treating clinicians.

The strength of the BCN in such a care coordination role comes from having an approach which is knowledgeable and 'inside' the system but which views that system always as having a woman at the centre. The broad span of the BCN role enables them to identify opportunities inside health care systems where work can be done to make multidisciplinary care feel as seamless as possible for the client. The BCNs have a unique capacity to cross barriers to information sharing which seem all too common between health providers and between public and private systems. As the BCNs cross these boundaries **with the women**, the breast care nurse exists as a versatile and indispensable member of numerous multidisciplinary teams.

SERVICE MODEL STRENGTHS AND DIFFICULTIES IN PRACTICE

Clear line and professional accountability for the BCNs was to the Breast Services Nurse Unit Manager. This meant the BCNs had a visible profile within the organisation, and gave them professional credibility.

The Social Work profession has a highly sophisticated understanding of the forces which could effect or block change inside health systems. This knowledge was offered to the BCNs and enabled them to help women negotiate and challenge these systems. The Southern Health BCNs were thus in an excellent position to capitalise on the existing expertise and knowledge base of the social worker.

An early challenge to the BCN project was posed by the enormity of the ongoing emotional and practical needs of many women after their treatment for breast cancer. These needs had been underestimated, with a working assumption having been made that with appropriate care coordination during active treatment, women would not continue to need or seek BCN contact after the end of that time. This turned out to be something of a false assumption.

When women with significant needs were unable to be referred elsewhere, the BCN risked sinking underneath a huge and ever expanding workload. Often, women found that community resources to which they had been referred by the BCN were so stretched that service was unavailable. However the BCN resource in the acute health sector was small and needed to be used to maximum benefit, that is, during the period of acute care.

The model established as part of the breast care nurse project included ongoing evaluation of the role and operation of the BCN team, including external evaluation. Having already welcomed professional input external to nursing, the BCN team approached this question of external evaluation with interest and in the expectation of helpful insights and positive change.

Two Masters of Business (Leadership and Organisational Dynamics) students from Swinburne University offered to undertake an action research study on the role and function of the Southern Health breast care nurses. The students, Sheila Hirst & Ralph Muir-Morris described significant differences between the breast care nurse role and more traditional nursing roles. The breast care nurse was described as unbounded by a "shift, roster or particular ward setting". The breast care nurse was identified as a "navigator" for the patient through a complex health system, a "familiar face", a confidante and mentor.

Hirst and Muir-Morris concluded that the combined nurse/social worker model of service development and management represented a service strength which helped increase breast care nurses effectiveness. This was considered particularly true in relation to the professional way in which breast care nurses linked women to other services, especially those services designed to help women deal with their social and emotional circumstances. The researchers

considered the Southern Health model, with its team approach and structure “supported the evolutionary nature of the role”.

OUTCOMES & CONCLUSION

The question of how to best match the service resource to women’s needs was a significant question and the project sought outside help in finding answers. This was critical as the care coordination function was at the heart of the BCN role. The external evaluation caused the project team to examine ways of putting some constructive, effective and sensitive limits to women’s access to the BCN resource. In order to find ways to routinely and formally ‘end’ contact between the BCN and client, the social worker and a colleague investigated and then established an ‘end of treatment’ group. The aim of the group is to help guide women back into the community without them feeling abandoned by the acute care treatment team. The group is tightly planned and has a structured program which runs over six weeks. It is currently facilitated by two social workers with some BCN input, and is affiliated with the Cancer Council of Victoria’s “Living with Cancer” program. It was the first disease-specific Living with Cancer program recognised by the CCV.

The model adopted – the BCN and social worker in partnership – represented some formal acknowledgement given to the well understood, well documented but sometimes formally ignored emotional toll on those undertaking direct contact roles for cancer patients. It is common in many clinical units to have unit based debriefing or support provided by a social worker, psychiatrist or psychologist. This project strengthened and extended this trend, and accepted the independent evidence of the need for clinical supervision.

The social worker had a mandate to work both individually and as a group with the BCNs and also had access to management with her views on what was needed in terms of system change and the impact of care coordination on the BCNs as a group. It is asserted that this focus on individual and group support and professional development has been a significant factor in the success of offering a care coordination service.

The decision to undertake a ‘nursing team’ approach with some practice supervision and support coming from outside the nursing profession has been a major strength in the development of a new service. This approach enabled the service, staffed by several part time BCNs to offer accessible service to many more of the women using Southern Health breast services than would have been possible had the BCNs held their own ‘caseload’. However there are certain skills to be developed to avoid BCNs taking on and being swamped by women’s problems and circumstances. It seemed clear from the outset that the Social Work profession had the capacity to work with the BCNs on the notion of teamwork, and to sort through with the BCNs what that overused term might mean for them.

It was also important that the BCNs offer their care coordination as a particular and overarching service, that they did not trespass on the accepted roles of other clinical health professionals, that they could accept limits to the service they offered and that they did not become an extra staff member for any particular unit operating in the breast services treatment realm. This was a new service by BCNs in new positions which would routinely be crossing organisational and professional boundaries. The original position descriptions were loose, as befits a developing role. However the potential pitfalls were also clear. Again the Social Work profession offered the most likely chance of a successful approach to successful care coordination. As the

profession probably best able to understand organisational change processes, a social worker was likely to be able to offer insights, strategies and support to BCNs struggling to effect changes in the organisation. The social worker helped contribute to the development of the BCN roles, to the development of sustainable positions and to the management of a nursing team managed as a separate unit, albeit in clear partnership with many clinical treating units. It is asserted that this distinguishing feature makes the concept of care coordination a reality even in a large service with many competing demands on individual service providers.

The enormous benefit of engaging a health professional external to nursing in the supervision and management of BCNs in this model cannot be overestimated. Both disciplines have benefited from a broadened knowledge base and better understanding of the needs of women and their carers following a breast cancer diagnosis. The BCNs had direct access to professional knowledge about how community resources actually work in practice and how to maximise the chances of a successful referral for a community service. This valuable information is not readily available by examining written or web-based information sources. The social worker in turn had easy access to relevant clinical information which could be incorporated into individual care plans being negotiated between social worker and client, with the BCN understanding of how and where such systems could be manipulated proving useful on many occasions.

BCNs have strengthened the several Southern Health based multidisciplinary teams pivotal to care planning for women with breast cancer. The BCNs were quickly appreciated for their uniquely woman-centred approach to both individual planning, care coordination and service review.

The responsibility for effecting seamless care coordination does not lie with a single discipline. The MDT team must be continually challenged to develop and sustain a basic commitment to the notion that women are central to the treatment process, not simply passive recipients of care. The team must develop protocols which can be adapted to individual requirements without losing their evidence based strength. All this is vital for care coordination to even be worth attempting. Assuming all the above elements are present, then the care coordination process pursues ways to provide care, access information, and to negotiate individual care from both clinicians and organisations.

Finally, but terribly importantly, regular clinical supervision sessions between the BCN and the designated social worker have proved to be effective, positive, challenging, reassuring, 'growth-inducing' and safe. This relationship involves trust as an essential feature as the capacity to use personal as well as professional reflection as part of professional growth could be ineffective in some contexts or even dangerous in unskilled hands. However literature supports the notion that reflection is central to any process by which experience becomes learning and is essential to improving and understanding practice.

We believe the Southern Health nursing/social work model acknowledges the needs of women, the needs of BCNs and fits well with existing service organisations in the region. To conclude, we believe there have been both significant and subtle changes to breast cancer care within Southern Health. These changes are directly associated with the establishment of the organisation's first BCN positions, and the nature of those changes has in turn been influenced by the nursing/social work model of service development and management.