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Author(s)	Giltenane, Martina; Kelly, Marcella; Dowling, Maura
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AUTHORS

Martina Giltenane

MHSc, PGD (Public Health Nursing), BSc (General nursing),
Public Health Nurse. Limerick Local Health Office
Primary Care Area 1,
Cloughkeating, Patrickswell, Co. Limerick, Ireland
m.gilteneane@hotmail.com

Dr Maura Dowling

PhD, MSc, RNT, BNS, RGN.
Lecturer, School of Nursing and Midwifery,
Áras Moyola, National University of Ireland, Galway,
Ireland.
Maura.dowling@nuigalway.ie

Marcella Kelly

MSc (Education), BSc (Community Health), RNT,
PHN, RM, RGN.
Lecturer, School of Nursing and Midwifery,
Áras Moyola, National University of Ireland, Galway,
Ireland
Marcella.kelly@nuigalway.ie

KEY WORDS

public health nurse (PHN), primary care, primary care team (PCT), interdisciplinary, teamwork.

ABSTRACT

Objective

This study aimed to understand public health nurses' (PHNs) views and experiences of their role as part of a primary care team (PCT) and developments within primary care.

Design

The study adopted a qualitative design guided by interpretative phenomenological analysis (IPA).

Participants

Ten PHNs who were working as part of a PCT for at least two years and who also had PHN experience prior to PCT development were interviewed.

Findings

Three super-ordinate themes representing the study participants' lived experience and meanings of PCT involvement were interpreted. 'We are a team' represents mostly positive experiences of being part of a team such as improved communication and teamwork. However, GP non-attendance at PCT meetings was also highlighted by all the PHNs. 'Pushed to the limit' revealed the PHNs' frustrations attributed to lack of resources. In addition, this theme represented PHNs' views of always having to 'take up the slack' within the team. Finally, 'PHN's role' revealed that the health promotion aspect of the PHNs' job was perceived to have been 'pushed aside', and mixed feelings around PHNs' future role were relayed.

Conclusion

The findings contribute to the knowledge of PHNs' roles as part of PCT developments and highlight the need for more dialogue among PCTs on all roles within the team. It is clear that more resources for PHNs in Ireland are needed if they are to fulfil a vision of primary care. In addition, the study findings point to a need to investigate whether policy and practice changes introduced with the introduction of PCTs has improved patient outcomes.

INTRODUCTION

Internationally, primary care is recognised as the most effective way to provide health services as it provides high quality easily accessible services for the community in a timely manner (WHO 2008). The evolution of primary care has demonstrated positive outcomes with regards to targeting individual and population health needs (WHO 2008).

There have been many developments in primary care in Ireland since the launch of 'Primary Care: A New Direction' strategy (HSE 2007; DoHC 2001) such as the launching of Primary Care Teams (PCTs) around the country (DoHC 2011). Nationally, PCTs work together to deliver local, accessible health and social care services to a defined population of between eight-twelve thousand people at primary first point of contact with the health service (DoHC 2012). According to the HSE (2009) interdisciplinary team-based working in primary care is the ideal approach to providing effective and efficient services at local level following from international counterparts. Public Health Nurses (PHNs) in Ireland play a key role in PCTs due to their generic role and function (Philibin et al 2010). However, they are faced with many opportunities and challenges as part of PCTs (Philibin et al 2010). A major challenge is particularly evident with 44% of the population in Ireland being over the age of sixty five and living in rural areas (Government of Ireland 2012), and this group is supported mainly by PHNs. And while other members of the PCT (e.g. occupational therapists and physiotherapists) are involved in the health care delivery of this particular population group, their specific caseload numbers are capped, resulting in long waiting lists for their specialist services (O'Neill and O'Keefe 2003). The consequence for the PHN is that this professional grouping are left to continue supporting this population group within PCTs, while other services are unable to provide specialist services (Philibin et al 2010). This in turn creates challenges for the PHN in delivering a nursing service as part of the PCT (Philibin et al 2010). Moreover, unlike community based nurses internationally, PHNs in Ireland are seen as 'all-purpose' generalist nurses caring for people of all ages, across the lifespan, in a geographical area, within a PCT (Philibin et al 2010). PHNs have traditionally provided the core nursing and midwifery care in the community, with community registered general nurses (CRGNs) in more recent years, supporting and contributing to community services (INMO 2013). Although the role of the PHN in Ireland involves some specialist role functions (for instance, child and maternal health) (McDonald et al 2013), in other countries, distinct titles are given to these roles which include; district nurses, community nurses and health visitors. District nurses care for people in their homes or residential care homes, providing increasing complex care for patients while supporting their families. They also teach and support patients and their families to care for themselves (Scott 2013). Health Visitors are registered nurses or midwives whose role involves health promotion, public health and working in the community to help families and young children (Christie and Bunting 2011). Community Nurses work closely with patients in the community to provide, plan and organise their care, and their work focuses mainly on those with serious long term complex conditions (Laws et al 2010).

While PCTs are central to the delivery of holistic and co-ordinated primary care, the literature reveals some challenges highlighting inter-professional tensions (Cioffi et al 2010; O'Neill and Cowman 2008). O'Neill and Cowman's (2008) Irish study shows similarities with Cioffi et al's (2010) Australian study regarding inter-professional disagreement among team members. Members of the PCT may not agree with client care management strategies of other health care professionals leading to tensions among team members (Cioffi et al 2010). Nonetheless, much of the literature reveals that teams working in the health service offers clients the highest quality and efficient health care from knowledgeable health care professionals (Sheng et al 2010; HSE 2009; Wilson 2005; Borrill et al 2003; Freeman et al 2000). Furthermore, many researchers also suggest, for a team to function well, it depends on communication and unity within the team (Sheng et al 2010; Carney 2009; Wilson 2005; Zabner and Gredig 2005; Freeman et al 2000).

Other issues for PHNs as part of PCTs include their health promotion role. Traditionally, PHNs were deemed to carry out health promotion in a defined geographical area (Hanafin, 1997). However, recent studies do not show any evidence of PHNs' health promotion initiatives (Burke and O'Neill 2010; Philbin et al 2010). It has been established that PHNs' role in health promotion is reduced due to workload demands (INMO 2013; Philbin et al 2010). The acuity of need determines patient priority, therefore, neonates and their mothers, older people at risk, patient discharges from hospital requiring dressings, terminally ill and bed-bound patients receive priority attention (Philbin et al 2010). Health promotion activities on the other hand are carried out opportunistically whilst caring for these patients and are of secondary importance (INMO 2013; Philbin et al 2010).

The future role of PHNs in Ireland within the PCT is unclear and a major challenge is to prevent the role being seen as a 'catch-all service' (Philbin et al 2010, p.748). Interestingly, in a review of the community nursing service by the Scottish Executive (2006) it emerged that role confusion and increasing trends towards specialist roles were prevalent. However, from the patient's perspective accessing one single discipline was preferred as opposed to the traditional specialist disciplines including; the health visitor, district nurse or school's nurse (Gray et al 2011). Therefore, a radical and new model of nursing was proposed whereby these specialist roles would be absorbed into one generalist community health nurse (Scottish Executive 2006), similar to that of the Irish PHN.

In response to this recommendation of a generalist role as a new model of nursing, Gray et al (2011) carried out a qualitative descriptive case study on 27 purposely-chosen community nurses working in one health board area in Scotland. The aim of this study was an in depth exploration of how community nurse practitioners and managers constituted role changes towards generalist working. Like Philbin et al's (2010) study in Ireland, the 'jack of all trades' was a common theme that emerged and was explored as a discursive strategy to undermine generic changes. Generalist working was outlined by nurses as being detrimental for patient care due to erosion of specialist roles (Gray et al 2011).

Finally, a more recent National study carried out by the Irish Nurses and Midwives Organisation (INMO 2013) found through a national survey of PHNs and CRGNs' work environment there is clear frustration of working in the community. The main issues highlighted by the nurses were staff shortages, huge caseloads, masses of paperwork without added support, difficulties with multidisciplinary/interdisciplinary team working, ambiguity of roles for both the PHN and the CRGN, and cuts to vital services. This study therefore is timely in view of the recent INMO (2013) study, and aimed to provide an in-depth account of PHNs' lived experience of their role as part of the PCT in Ireland.

METHODOLOGY

This study adopted interpretative phenomenological analysis (IPA). IPA is an approach to qualitative, experiential research which is phenomenological in nature as it seeks an insider perspective on the lived experience of individuals (Smith et al 2009). Purposeful sampling was chosen. Inclusion criteria were both having worked in a uni-disciplinary capacity and of having worked or currently working for the past two years as a PCT member. Participants who have had this range of experience were chosen as they are best placed to share experiences of transition to PCT member. The PHNs that were interviewed came from both rural and urban areas of practice. Six of the participants worked in the same building as other PCT members. Two of the participants were working as part of a PCT for three years, seven were working as part of a PCT for five years and one was working as part of a PCT for over eight years. Two of the participants were qualified over twenty years, two over fifteen years, four over ten years and two under five years.

In accordance with the inherent assumptions of IPA, considering researchers' prior knowledge and presuppositions are important (Smith et al 2009). With IPA, the researcher's pre-understandings are viewed as '...necessary precondition for making sense of another person's experience' (Willig 2008, p.69). The lead author is a qualified PHN and has experience of working as part of a PCT in the current economic climate. However, researchers using IPA are advised to 'park or bracket...pre-existing concerns' to allow them focus on the study participants' accounts of their lived experience (Smith et al 2009, p. 64).

Ethical approval was granted by the region's research ethics committee. Letters of invitation were sent inviting PHNs to be interviewed. Ten PHNs volunteered to be interviewed. The first author conducted all ten interviews and used a semi-structured schedule. The interviews lasted between thirty and forty-five minutes. All interviews were transcribed verbatim. Smith et al's (2009) interactive and inductive cycle for analysis was used to guide the analysis. Participants were assigned a pseudonym.

FINDINGS

Three super-ordinate themes with subthemes were interpreted from the data (table 1).

Table 1: Super-ordinate and sub themes

Super-ordinate themes	We are a team	Pushed to the limit	PHN's role
Sub-themes	Communication: The good, the bad and recommendations.	'Primary care has pushed so much in'	Cradle to the grave service
	PCT meetings	Limited resources	Loss of health promotion role
	Supporting each other	PHNs documentation system not capturing role	PHN role will change

We are a team

Since the development of PCTs in Ireland, communication, relationships and teamwork had improved among PCT members. PCT meetings were seen as a "fantastic" way of enhancing communication through face-to-face interactions, which also motivated team members, improved trust and respect among team members, and ultimately benefited patients.

However, participants also highlighted a breakdown in communication between primary and secondary services. Participants were frustrated with the expectations of hospital staff that they felt were unrealistic, such as; inappropriate referrals from the hospitals or even no referral at all.

'(...) I wasted my time going to two clients so in total I probably wasted two hours of my time going to clients that didn't actually need my visit (...)' (Chloe).

'Number one they are sent from X hospital without letters. They go in get abscesses lanced and different legs treated and just told 'go to the nurse in X'. No referral system, no letter for me' (Amy).

All participants were very positive about PCT meetings. They highlighted that PCT meetings were 'very good', 'very beneficial' and 'very effective':

'At least once a month now we would meet the team and I could say 'look I saw this patient' and if the GP had seen him at least we both know where we are coming from. We can both give our opinion on what approach we would like the care to go on for this problem' (Jamie).

Participants talked about PCT meetings being on a monthly basis. However, fortnightly meetings were highlighted as having the most benefit. Nevertheless, due to workload demands of PCT members, fortnightly meetings were thought to be unrealistic:

'Well it [fortnightly meetings] would be beneficial but it wouldn't be acceptable really because everybody is so busy at the moment. Everybody is stretched really. Every two weeks it would be just impossible to find that time but it would be beneficial if you had the time' (Jenny).

The nurses also highlighted that 'everybody's input is as important as the next' (Lacie) at the PCT meetings:

'(...) when we do come together it works but when we don't come together it doesn't work as well' (Sadie).

They also expressed particularly the importance of GP attendance:

'So I feel sometimes that if the GP of the client you are discussing isn't present... that is a challenge' (Katie).

'I suppose, a downside, the GPs aren't as involved as I'd like them to be but where the GP is involved with that patient you can sort of push home what you need from them' (Maisy).

This issue of GP non-attendance echoed throughout the nurses' narratives and they expressed frustration that GPs did not see PCT meetings as beneficial and that everything was being done to accommodate the GP yet they still would not come. Due to GPs not attending meetings, leads to further issues such as lack of role clarity, and the nurses highlighted that role clarity among PCT members depended on PCT meeting attendance:

'Everybody realises when you sit at the PCT meeting what their role is' (Jenny).

'It always extends back to the GP not attending the meetings so they don't know then what our roles are' (Elly).

Despite the many challenges of working as part of PCTs, the feedback was predominantly positive. The responses from participants included the viewpoint that there was better support for PHNs now, patient care was shared among the PCT and joint visits were found to be very effective and efficient. Team stability was also highlighted as a means of effective teamwork and the nurses acknowledged it is the patient that is at the centre of primary care:

'Yes I find working in the PCT a huge difference and a great benefit. (...) You feel that you are not 'carrying it on your own shoulders', that you are within a team and it is shared (...)' (Katie).

Pushed to the Limit

Participants highlighted that their workload had 'increased dramatically' since the introduction of primary care, without the associated supports. Paperwork had increased and PHNs were even resorting to operating waiting lists in order to cope with the pressure:

'Our service can go extremely busy and it's still the same nurse that is on trying to cover that area, trying to keep on top of it. She is trying to provide the same service that she is trying to do always, but when the workload increases, it is very difficult to do that. That is what I feel. No extra money was invested in staffing levels to support the 'free for all' (Katie).

'You are chasing. You are trying to do twelve, fourteen visits a day. So you are catching your tail the whole time' (Chloe).

Many of the participants also felt overwhelmed with the amount of paperwork they have to do now compared to prior to PCT involvement:

'(...) you do, you have to document, which is important, but there is an awful lot of documentation for everything. There is duplicated documentation. (...) There is so much clerical work to do. It is very hard to give a quality driven service when there is so much pressure' (Lacie).

In order to counteract the workload demands, participants highlighted that they prioritised their workload by operating waiting lists, but they had difficulties with this:

'(...) I had a client last week and I could've left him until this week and I have no doubt that he would probably had a pressure sore I could have put my hand into. (...) Yes I would have a little waiting list and I have had to defer. You try and do your best and that is all you can do' (Lacie).

A lot of time is spent on the phone dealing with queries and this work goes unrecognised due to the fact it is not recorded on the workload returns:

'(...) but I did that all on my own time maybe from eight to nine on a night. But I never put it down as my workload and I should have actually because it was very important' (Chloe).

However, this lack of documentation may be out of the PHNs control and a need for an improved recording system was highlighted by Elly:

'Because if you look at the return system there is no space on it to say 'new PCT referral'. Which you could be putting in two or three a day. So that is not being recognised. In the Physio and OT system, when they get a new referral the co-ordinator will put it up on the system but for us that's not being recorded anywhere. (...) I am just saying in figures and statistics it's not being recognised. (...) That needs to be sorted out' (Elly).

PHN's role

Many of the participants expressed concerns that they always seemed to be the 'first port of call' for other PCT members. Participants felt that whatever did not fit the job description of the other disciplines within the PCT, it ended up on the desk of the PHN to 'sort it out'. Educating team members on each other's roles was deemed important by participants:

'At the very start we gave a presentation and maybe at six months in we gave a presentation again. (...) you know they all think we do nothing else but their defined role and to make them understand that we have a huge vast population and what we do' (Maisy).

'(...) I'd say actually the biggest barrier would be this whole grey area. There is always a grey area. If it's not black or white, if it is not strictly Physio or if it's not strictly OT or if it's not strictly medical it seems to be 'lumped on' to the PHN' (Jamie).

Many of the participants expressed disappointment that the health promotion aspect of their role has been pushed towards a more curative aspect as opposed to preventative role. However, many participants reported carrying out individual opportunistic health promotion where possible showing a duty of care for their patients:

'(...) there's no definite role in health promotion, there's no real say that it is part of our role am not really' (Sadie).

'I would say in the last six or seven years we had a little bit more time for preventative work. Now it's all task orientated. I would worry about that' (Lacie).

A sense of uncertainty regarding role changes into the future was evident among participants, and comparisons were made with the UK:

'Downhill and I do I see it [public health nursing] going downhill. Eventually we will become just like England we will be a health visitor and you will have RGNs like District Nurses carrying the loads... It is diluting the role because it's all about money, cost and at the end of the day having an RGN, taking a caseload it's a lot cheaper than training a PHN and paying a PHN' (Amy).

DISCUSSION

This current study is timely and enhances the INMO's (2013) findings by providing a deeper insight and meaning into lived experiences of PHNs. This study reveals that since the development of PCTs, the PHN role has also expanded within primary care, without the appropriate resources to cope with the increased workload. The increased volume of paperwork since PCT involvement is also a central concern highlighted by PHNs. Moreover, PHNs' contribution is not visible in terms of documented outcomes. This latter finding is important and signals a need to examine current documentation systems. A possible solution is a method of documenting population-based nursing practice by adding population-based interventions to an underlying electronic health information system (Baisch 2012).

Auckland's (2012) literature review on caseload numbers for community nurses in the NHS highlighted similarities to the findings reported here in that caseload numbers have been recognised as an issue causing anxiety and stress among community nurses. However, community nurses may have fourteen complex patients to care for, whilst health visitors may have eighty to a hundred child health families to care for (Auckland 2012). In comparison, a PHN in Ireland works as a generalist covering all aspects of community care with no cap on numbers, therefore caseload numbers can be much higher than this. Nationally, the average PHN caseload ratio is one PHN to three thousand of a population (HSE 2011) which is constantly increasing due to an aging population (McDonald et al 2013).

The participants in this study identify that face-to-face meetings motivate PCT team members, improves trust and respect among team members. However, due to workload demands participants expressed the desire for improved communication in order to be more efficient and better able to manage their caseloads without the added pressures due to communication breakdown. Similar to the findings reported elsewhere (Arksey et al 2007), the findings reported here reveal that there remains much room for improvement in order to facilitate better communication for PCT members.

A major concern highlighted by participants was the non-attendance of GPs at PCT meetings. However, in Ireland GPs may be assigned to several different PCTs due to their geographical location rather than general practice registration, inhibiting PCT meeting attendance, which is a major barrier to PCT functioning (ICGP 2011). The concept of geographical catchment areas has been a long established practice in community psychiatric services in Ireland but causes many problems for patient access to services (ICGP 2011). For example; a patient may be attending a GP in a health centre but may not be eligible to be seen by a PHN working in the same centre due to their home address being outside the geographical area of the PHN.

Nonetheless, PHNs prefer to work within a geographical remit as opposed to being attached to a particular GP as they would find it more difficult to provide care exclusively to patients of GPs in the team (Burke and O'Neill 2010). For those teams that do have GP involvement and regular attendance at PCT meetings, it was reported that these teams are working effectively. Similarly, O'Riordan (2012) highlights that PCT meetings attended by GPs offer the opportunity to approach difficult clinical or social problems with a broad range of skills and knowledge.

Although attending meetings was highlighted as important for role clarity, educating team members on each other's roles was also deemed important by participants. A similar finding is also reported by O'Neill and Cowman (2008) who found PHNs' value the importance of role clarity among all team members, especially at the early stages of team formation. Developing a communication group, after hours socialising, more efficient computer systems and a review of working arrangements not only improves communication, but could improve role clarity and team functioning (Arksey et al 2007).

Many participants reported that the health promotion aspect of the job has been 'pushed aside' since the introduction of PCTs. In Ireland, the community PHN service has become more like a 'fire brigade' service with PHNs managing those acutely ill and losing the health promotion role (INMO 2013). In Sweden, a similar situation is reported by Wilhelmsson and Lindberg (2009), who found that PHNs focus on medical tasks rather than health promotion due to time limitations. Irish PHNs' role in health promotion has been shown to have reduced due to workload demands (Philibin et al 2010). The acuity of need determines patient priority, therefore, neonates and their mothers, older people, patients discharged from hospital requiring dressings, terminally ill and bed-bound patients receive priority attention (Philibin et al 2010). Nonetheless, many participants reported carrying out individual opportunistic health promotion where possible, a finding also reported by Philibin et al (2010).

Comparisons with community nursing in the UK were made by the PHNs, with predictions that the Irish PHN role would be divided into three strata; health visitor, district midwife and district nurse. However, role confusion can be caused when nurses are organised into specialist roles (Scottish Executive 2006). From the patient's perspective accessing one single discipline is preferred to accessing the health visitor, district nurse or school's nurse separately (Gray et al 2011).

This study has a number of limitations. The hermeneutical interpretation embedded in IPA is individualistic, thus the interpretation is never fully complete. This study is also limited to understanding the views and experiences of PHNs, whilst there are many other members of the PCT.

IMPLICATIONS

PHNs in Ireland indicate that more resources are needed for them to carry out health promotion initiatives and fulfil the vision of primary care. The findings of this study also suggest a more efficient electronic database may improve communication among PCT members and between primary and secondary services. However, full attendance at PCT meetings is needed along with teambuilding exercises and socialising to build relationships and team functioning. The next step is to test whether changes to policy would improve patient outcomes using prospective interventional methods, such as a cluster randomised control trial. This type of methodology would be ideal as it would allow comparisons to be made between patient outcomes of those attached to PCTs and an intervention group in which PHNs have a capped caseload number, thus allowing more time to carry-out health promotion activities. Finally, if the PHN role is to change to a specialised one, PHNs may need appropriate up-skilling and education.

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