New Entry To Practice (NETP) Hauraki Thames Coromandel Combined position 2 years on

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Hauraki /Thames / Coromandel

HTC NETP placement:

History:

Requirement for NETP positions placed in Rural areas / community

NETP positions need to be 0.8FTE or greater

OMG… really……??? How are we supposed to do that ?
Yep, really.
But……. We don't employ people with less than 5 years experience….& we don't have any places and we don't ……Bugger…….

HTC services:

Services include District Nursing and Public Health nursing located permanently in 6 bases with visiting allied health from Thames
DN has 15.6 FTE and provides a 7 / day week service with on-call for end-stage / unstable patients
PHN has 5.5 FTE Monday - Friday

Hauraki Thames Coromandel: Demographics etc…(the stats)

Thames / Coromandel District population is **26,178**.

Median age is 51	NZ: median age is 38
27% are over 65	NZ: 14.3% of total population over 65
16.6% are Maori	NZ: 14.9% of total population
Median income $23,200	NZ: $28,500

43% have an annual income of $20,000 or less. NZ: 38%

Hauraki District population is **17,808**.

Median age is 45	NZ: median age is 38
22% are over 65	NZ: 14.3% of total population over 65
21.2% are Maori	NZ: 14.9% of total population
Median income $23,100	NZ: $28,500

44.5% have annual income of $20,000 or less.

Total population: 43,986

We have a high population increase over the summer period to **120,000**. Transient holiday makers and ‘holiday home’ owners. This places pressure on our infrastructure and resources during this time.

Geography:

The Coromandel Peninsula is basically a mountain range with small townships located either side on each coast, extending down to Waihi Beach, across to Paeroa and the Hauraki Plains.
Beautiful beaches and fresh water rivers, tramping tracks and the Hauraki Rail trial. ☺
There are few small towns located in land – these are mostly 'the plains' towns
There are some fairly isolated communities and access can be challenging
Roading is reasonable, not all communities have sealed roads.
Access can be restricted by severe weather components, flooding and high winds are the main issue.

Bases:

Thames / Coromandel Town/ Whitianga / Whangamata / Waihi / Paeroa.

All bases have permanent DN & PHN staff with visiting allied health professionals
Community Mental Health services are usually co-located in the bases.
Nursing staff work autonomously, and alone at times.

Challenges:

- Neither service had 0.8 FTE available
- Neither service had vacant position in any base for 0.8fte
- Neither CNM felt comfortable having a new graduate practicing autonomously / alone in a rural base with no daily support / supervision
- Neither service really had the capacity to have a 'supernumery' RN, particularly with focus on productivity data and current financial climate.

HOWEVER:

We took up the challenge because:

- We have a belief in the importance of Rural Community Nursing
- We understand that student nurses do not have much exposure to community nursing, therefore it is not viewed as a 'career option'
- We believe that our staff have excellent skills in assessment & evaluation which underpins all areas of nursing
- We understand that we need to plan for the future and develop and encourage new nurses into the community

How do we do this????

Once upon a time in the HTC DN's & PHN's were called community nurses and did both roles, Tamariki Ora & sometimes even worked in the community hospital as well…….. (see History does repeat itself)

We brain-stormed: What did we want, and what did we want the person to come out with at the other end –
It was highly likely there WAS NOT going to be a permanent position available in either service
We have a fairly stable workforce.
However: if we did have a vacancy we would want this person to be able to confidently apply for it.

What we were looking at:

- A new NETP every year.
- Implications for the PHN service: the schools have a new nurse every year. Not great for the continuity and relationship building that is so important in community based nursing services.
- Staff precepting / mentoring new staff member every year.

These needed to be considered and managed on an on-going basis.

What we decided:

We could do a combined role DN / PHN 0.8fte
The PHN based in Paeroa had been seconded to the School Nurse role 0.4 FTE which provided 0.4fte
The DN service applied for 0.5 FTE
This combined FTE was used to create the 0.8 FTE with 0.1 being temporarily allocated to the PHN preceptor

We wanted the nurse to come out with sound clinical assessment and evaluation skills that would allow the RN to move into any area
i.e: Nursing process skills that are embedded in every day practice. This underpins all nursing practice and is particularly important in rural community nursing.

"A community focused nurse with sound assessment and evaluation skills, and is a safe practitioner. There are more commonalities than we realised"

Two Years on….

We currently have our 2nd NETP
As we predicted, there have been no ‘suitable’ vacancies.
We have alternated bases between Paeroa and Waihi & will continue to do so
We had to consider the impact on the schools

The NETP works 2 days / week as a PHN & 2 days / week as DN

What we learnt from the first NETP:

- We need to meet regularly with NETP & preceptors to monitor progress and encourage ‘patient workload’
- Monitor the areas where skills need to be developed
- Be very clear / prescriptive about where to focus ‘energy’
- Continence assessment and enuresis/ encopresis work nicely together
- Be realistic about workload management – both having enough to do and being safe. E.g: palliative patients

The good, the bad, and the ugly

The good:

Our first NETP scored a full time job at the medical center and stayed in Waihi!
The medical center thought they won the lotto.

The staff have enjoyed developing themselves as preceptors and realizing that they know a great deal about a great deal of stuff – and it's important
The staff have learnt more about each service and there are more similarities than they realized- has also improved collegiality.

We needed to interview the people for the position – the first NETP we had no idea who she was or what sort of previous experience she had

The bad:

Its not that bad – we (CNM's) need to have more input in to the precepting and development role – however now Andrea (NE) is on board it makes it much easier.
Being located in Thames with NETP in outer base has made this a challenge.

Sometimes there has been very limited experience in community

The ugly:

It's not really that ugly either…..
There are many many many NETP study days- university days, service education and so on

By the time all the education is done there isn't a great deal of time left to do work – in either service (well it seems like it some times)

Keeping the balance between both services and the education time equal between both services can be a bit testing.

Then after we have done all of this in a year – it's time to start again..

The end..and all that.

It's good for our staff
It's good to see new nurses grow into realizing what rural community is all about –

Debunking the myth:

- ☺ You don't need to be an ED nurse to be a star or be challenged
- ☺ You can work in the community and make a difference and learn lots!
- ☺ You do not have to have 3+ years in a ward first – we realized that the new nurses now have more of an ability to critically think – what they need most is the confidence and opportunity to learn, grow and develop

These nurses may never work in an in-patient unit – and why should they?