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Meeting the needs of marginalised children: An innovative Nurse Practitioner led health care model at Uniting Care Wesley Bowden

By Yvonne Parry, Eileen Willis, Sally Kendall, Rhonda Marriott, Nina Sivertsen and Alicia Bell

The Department of Health, *Action Plan for Children and Young People* states 22% of all Australian children live in housing instability (Australian Government 2019).

Australian research states one in six children or 1.1 million children live in disadvantage or are marginalised (Davidson et al. 2018; Long et al. 2018; Sandstrom & Heurta 2013). Marginalised children are exposed to health inequities that result from socio-economic status, low SES communities, housing instability, lower parental education levels, and limited access to developmental supports and resources (American Academy of Pediatrics 2013; Pennsylvania 2014; Australian Government 2019).

Children experiencing multiple health determinants have increased levels of health inequity (American Academy of Pediatrics 2013; Parry et al. 2016; Parry, Ullah et al. 2016).

Collaborative research with the homelessness sector identified that current health service delivery models do not meet the needs of children living in housing instability (Department of Health 2018; Lau et al. 2016; Parry et al. 2016; Parry, Ullah et al. 2016; Rutter et al. 2017).

Children living in housing instability have poorer access to health services and appointment compliance, increased Emergency Department (ED) utilisation, and overall poorer mental and physical health outcomes (American Academy of Pediatrics 2013; Davidson et al. 2018; Goldfield et al. 2017; Pungello et al. 2010; Strong Foundations Collaboration 2019).

NURSE PRACTITIONERS

Nurse Practitioners (NP) are ideally situated to deliver cost effective and innovative models of healthcare (Adams & Schofield 2009; Jennings et al. 2015; Martin-Misner et al. 2015; QGH 2017; Woo et al. 2017;). All NPs can provide models of care using combinations of nursing care, diagnostic activities and intervention-based treatments, including the use of medicines (Adams & Schofield 2009; Jennings et al. 2015; Martin-Misner et al. 2015; QGH 2017; Woo et al. 2017.)

A nurse practitioner program has been introduced by Uniting Care Wesley Bowden in collaboration with Flinders University College of Nursing and Health Sciences to provide for children living in housing instability. The program will result in:

- Increased acuity of care to meet complex health and social needs.
- Holistic, advanced and comprehensive assessments.
- Extended collaborative care services eg. longer support and consultation/ treatment times.
- Supported interdisciplinary referrals addressing the multimodal interventions required by children

This structured, community embedded, intervention by a paediatric ED nurse practitioner (NP) with the skills to provide an advanced paediatric full health assessment of the children aged 0-18 living in housing instability provides linkages to early intervention mental and physical health services. The NP supports the family to improve the uptake of referrals to medical, allied health and mental health services to improve health and wellbeing outcomes for children. The NP support parents to navigate and participate with various interdisciplinary services (figure 1) required by children.

Expanding the use of NPs to meet the community and marginalised populations needs is an example of practical ways in which nurses operate to their full scope of practice.

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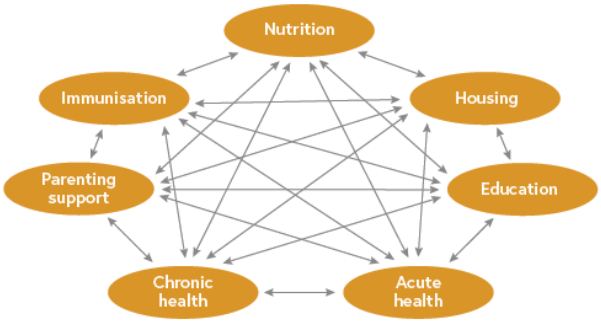
FIGURE 1: REFERRAL NETWORKS AND NEEDS FOR CHILDREN



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Addressing the experience of moral distress in community health nursing

By Diana Guzys, Kathleen Tori and Carey Mather

Moral distress, a phenomenon increasingly identified in nursing practice (Rushton 2017), results when the integrity of professional identity and internalised values are disrupted due to constraints placed on professional practice (Morley 2019; McCarthy 2015).

Perceived inability to act in accordance with best practice has been proposed as a contributing factor in the experience of moral distress (Whitehead 2015). Moral distress is linked to burnout, high staff turnover and professional attrition (Rushton 2016; McCarthy 2015).

Much of the focus in nursing literature relates to the experience of moral distress and high acuity care roles, however moral distress similarly occurs in community health nursing, due to organisational and practice constraints restricting the delivery of optimal healthcare.

Targeted funding and other efficiency strategies such as service rationing constrain healthcare practice, undermining professional values and identity (Austin 2012; Musto 2012). Nurses must recognise and act to address the influence of systemic constraints on professional practice and agency.

Despite having a professional and ethical responsibility to challenge less than ideal practices, traditionally nurses have not been explicitly educated to use skills to influence and improve the practice environment.

Contemporary nurses must be confident to appropriately address issues of concern for themselves, colleagues and on behalf of patients or clients.

Genuine understanding of nursing ethics and ethical responsibilities of the profession, adopting an attitude of leadership in nursing, as well as skills in critical reasoning, critical reflection and recognising the socio-political embeddedness of health and healthcare are required.

Due to its mandate for population health political advocacy is particularly relevant to community health nursing practice (Spenceley 2006). Community nurses become more politically competent through critical examination of health policy and participation in professional bodies.

Confidence to appropriately act to create change in the practice environment empowers moral resiliency. Factors contributing to moral distress in community health nursing need to be addressed to reduce the negative consequences of experiencing ongoing moral distress and prevent attrition from the nursing workforce.

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