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BCHCP Process Evaluation Communiqué #7 | September 30, 2015
Organizational Capacity – Impact on Implementation of Nurse-Family Partnership

One of the goals of the Process Evaluation is to identify contextual factors that influence implementation of the Nurse-Family Partnership (NFP). In the interviews conducted between April 14 and August 11, 2015, BCHCP Process Evaluation public health nurses (PHNs) (n=10) and BCHCP randomized controlled trial (RCT) PHNs (n=42) were asked to reflect on the factors that facilitated their capacity to deliver NFP to their clients as well as factors that made it challenging. Five themes related to organizational capacity that influence intervention implementation emerged which are congruent with current implementation science theory: 1) organizational support for NFP; 2) organizational climate and culture; 3) physical office environment; 4) human resources; and 5) access to technology. [1 2]

"Having a manager that really believes in [NFP], even though she had other public health responsibilities, she kept advocating for us...I was still feeling quite stressed about dynamics in my health unit not being happy about NFP. I feel like that's dissipated because we've just had this consistent advocacy for the program… And having me reporting back to them [non-NFP PHNs] *about the effects of NFP seemed to change our culture quite a bit."* – **NFP PHN**

Organizational Capacity Factors Influencing NFP Implementation	PHN Reflections of Factors That Influenced Their Capacity to Deliver NFP
1. Organizational Support for NFP • Commitment to NFP Implementation	**Strengths:** In some Health Authorities (HAs) NFP PHNs perceived that senior management were committed to NFP which created a culture that facilitated PHN capacity to deliver NFP; where support was perceived to be generally lacking at the management level, program advocates provided detailed information about the program to increase its perceived value. **Challenges:** In some cases lack of support for NFP at the management level has persisted, which is believed to be related to budget pressures and limited resources within the HAs, particularly public health nursing resources.
• Support for NFP Education and Related Professional Development	**Strengths:** PHNs appreciated the time, resources and support contributed to the NFP education and related professional development – which resulted in growth in their nursing practice and broader skillset to engage with complex NFP clients; annual face-to-face meetings provide an opportunity to share and learn from one another's experiences, further building their skillset, clinical nursing practice capacity, and team capacity (within and across HAs). **Challenges:** In some HAs, lack of resources provided to travel to some NFP education and related professional development events made it challenging for PHNs to deliver NFP, and also left them feeling that their work was not being valued, particularly when other HAs were sending their NFP PHNs to such sessions.
• Internal Policies That Support Disadvantaged Clients	**Strengths:** Flexible work schedules which support NFP PHNs working evenings or weekends if required have contributed to the NFP PHNs being able to provide client-centered care in terms of scheduling around client-identified needs; the ability to provide client transportation enables PHNs to build their relationships with and stay

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• Internal Policies That Support Disadvantaged Clients continued	connected to clients, which in turn increases client engagement in NFP long term. **Challenges:** Some HAs have policies restricting transporting clients; some perceived lack of clarity at management level regarding policies related to providing transportation to NFP clients and communication of these to NFP staff; PHNs found it challenging to deny clients transportation, particularly those living in poverty.
2. Organizational Climate and Culture • Impact of Management and Supervisors	**Strengths:** A work environment with supportive managers and supervisors allowed NFP PHNs to feel comfortable approaching them with NFP-related concerns, both personal and client-focused, which then allows them to strategize about solutions together. Supervisors advocating [for NFP] at the management level contributes to the creation of a supportive work environment. **Challenges:** A small number of NFP PHNs in several HAs identified that management support was lacking and felt frustration over the way that NFP has been managed in their HA.
• Relationships with Non-NFP PHNs	**Strengths:** Gradual shift from an attitude of negativity directed at NFP PHNs to one of a more positive nature, has in part attributed to the advocacy role played by the supervisors; some NFP PHNs are now perceived to have expert knowledge and skills for providing services to vulnerable populations and are sought out for advice and guidance on community resources and clinical practice. **Challenges:** Some tension between NFP and non-NFP PHNs related to the additional workload with nursing resources being re-allocated to NFP plus the small caseload of NFP PHNs compared to that of regular PHNs even given that NFP caseloads involve service provision, at a higher dose, to higher risk women and children.
3. Physical Office Environment • Working with Other NFP PHNs Onsite or in Close Proximity	**Strengths:** NFP PHNs with team members physically located within the same office or in close proximity identified that such situations provided opportunities to debrief, learning through peer reflection and to discuss and improve their professional nursing clinical practice. **Challenges:** NFP PHNs working in isolation found it challenging to conduct team meetings and case conferences by telephone rather than face-to-face; lacked access to informal nursing support that was provided to their other NFP colleagues; difficult to arrange coverage for vacation and illness.
• Office Space for NFP Program/ /NFP PHNs	**Strengths:** NFP PHNs with mobile offices where they are able to do some work from home or other locations found this allowed them to maximize time between visits by scheduling and planning for home visits as well as charting. **Challenges:** Some NFP PHNs share office space which is often utilized for other functions such as immunization clinics; NFP PHNs working in open pods conveyed that they have little privacy, and find it challenging to maintain client confidentiality when others are listening in; some NFP PHNs lack dedicated office space altogether and have to search for a desk and computer to complete their charting.
4. Human Resources • Balancing NFP work with another PHN assignment	**Strengths:** Having NFP as their only assignment allows for greater flexibility to locate clients, schedule visits to accommodate client preferences, participate in all NFP required supervisory and team meeting activities, and engage in NFP education and professional development; for those NFP PHNs who were also assigned other PHN work, support from management and supervisors in providing flexibility in their schedule and having the ability to alter these when and as needed was very helpful. **Challenges:** Dual PHN assignments are difficult to balance as often one or the other requires added hours over those allotted; when pulled away from NFP work (for example to help provide immunizations) they are not always able to prepare sufficiently for their NFP client visits; as a result some NFP PHNs have worked extra hours that they are not accounting for; maintaining communication and coordination between two or more supervisors and/or managers with regards to position expectations, requests to attend trainings, scheduling coverage, etc., requires permission through various layers who might not all be communicating with each other; difficult to maintain competencies in both NFP and public health nursing related work.

5. Clerical/ Administrative • Tools to Support Community-Based Work	**Strengths:** In HAs where NFP PHNs receive clerical/administrative support, they are incredibly grateful for the support provided which facilitates their ability to have program materials prepared and maximize time that they are actively engaged with their clients. **Challenges:** In HAs where NFP PHNs receive clerical/administrative support, this resource may be provided for a range of programs, without a support person being designated solely to NFP; some NFP PHNs also do not receive any clerical/administrative support, and therefore do their own photocopying, faxing, downloading program materials, etc.; concern expressed that as they reach full NFP caseloads (20 clients per full-time PHN), they will not be able to handle clinical responsibilities along with these clerical/administrative tasks.
6. Access to Technology • Tools to Support Community-Based Work	**Strengths:** Some NFP PHNs have laptops and air cards that provide for offsite internet access in order to maximize their efficiency working with their clients in the community, which has decreased the need to return to the office and increased the time available for clients, as well as the ability to chart between home visits; Provision of text-friendly cell phones is an important client engagement tool as most communication with clients between home visits is via text messaging rather than telephone. **Challenges:** NFP PHNs with older-style flip telephones feel that they are spending extra time sending text messages which is making communication with clients cumbersome and inefficient; Some NFP PHNs do not have their own laptop or computer and therefore share these resources with other colleagues within their HAs, which can delay their ability to chart in a timely manner.

"It's really hard to logistically keep up to date with my generalist role and all the other things I do as a public health nurse and the NFP work at the same time… There's not enough time for me to feel that I'm doing the program, the NFP program, with all of its complexities and all the tools that we use really, really, really well because of the workload that I have." **– NFP PHN**

"Another organizational challenge for us is having zero administration support. We spend a lot of time on administration. We're blessed in that we're not at full capacity and I don't know how we would do that if we were because we have no admin support." **– NFP PHN**

"I know where I work we're, we're… actually it's very positive and they [other PHNs] *want the RCT to be done so that we can take them* [women eligible for NFP] *all. They, they get quite disappointed when they get a control client because they went, 'oh they could've totally done well with you guys'. And so on the frontline, at least in my health unit, there's a real acceptance of the work that we do."* **– NFP PHN**

"I think that we have a really supportive group of managers that initially were maybe not so supportive and it was a challenge. But over time I think that most of them have kind of come around and see the value in NFP and are a little bit more supportive. So I think that shift has been positive." **– NFP PHN**

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[1] Damschroder, L., Aron, D., Keith, R., Kirsh, S., Alexander, J., & Lowery, J. (2009). Fostering Implementation of Health Services Research Findings into Practice: A Consolidated Framework for Advancing Implementation Science. Implementation Science, 4, 50.

[2] Hill P, Olds, D (2013). Improving Implementation of the Nurse-Family Partnership in the Process of Going to Scale. In Halle T, Metz A, Martinez-Beck I (Eds.) Applying Implementation Science in Early Childhood Programs and Systems.. Brookes Publishing Company, Baltimore, MD.

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