Family concerns

To achieve positive outcomes, PHNs must be consulted in the setting up of the government's Child and Family Support Agency

PUBLIC health nurses must not be overlooked during the initial stages of the establishment of the new Child and Family Support Agency. This is according to Patricia Marteinsson, chairperson of the public health nurse (PHN) Section of the INMO. She was speaking ahead of the Section's AGM at INMO headquarters in Dublin recently.

Ms Marteinsson is a PHN with a child health remit in Offaly. She cares for children up to 18 years, including those with disabilities. As a result of her work, she has come to believe that early intervention is essential in identifying and managing developmental and behavioural issues in children and the family.

"The role of the PHN is essential in working with families to prevent children ending up in social work care," she said.

Child and Family Support Agency

Minister for Children and Youth Affairs, Frances Fitzgerald, also believes that early intervention is key when it comes to changing the lives of vulnerable children for the better. She said that the CFSA will attempt to facilitate this positive change by bringing together child protection services, education and welfare, youth justice, adoption and fostering, youth services and early childhood care.

The CFSA is to come into being this year, and Ms Marteinsson believes that PHNs could help to inform the Agency in the early stages of its design and about how it should operate.

She said: "In order to achieve outcomes there should be more of a partnership with PHNs at the upper echelons of the CFSA, when all of this is being thrashed out. There is a potential to bring real and meaningful change to the families in the State."

About 4,000 staff have been identified for transfer to the Agency, including community psychologists, primary care professionals, the pre-school service, and sexual and gender-based violence services. However, community nurses are not yet included in this staff cohort. An industrial relations process is currently underway to achieve this.

Ms Marteinsson says that there is a fear among PHNs that their role could change if they are to be transferred to the CFSA.

"The role that the PHN has with families is so important and it cannot be subsumed into a social worker PHN role," she commented. "That won't work, because the way we are seen by the community will change and we will no longer be as welcome by patients as we were."

A large part of Ms Marteinsson's PHN role is to visit mothers, who have been discharged from hospital, sometimes just 24 or 48 hours after giving birth, to help them become established in their role as parents.

She also organises a clinic in the morning, which offers a drop-in service and facilitates regular health checks for baby and parents. "At those visits we check for things like fine motor skills, gross motor development, and whether the parents are adapting to their new role. We advise them on things like feeding and see if there are any issues that they have. At the three-month check, we check to see if anyone is in any way depressed by asking them some questions," she said.

If a new mother is showing signs of depression, Ms Marteinsson will conduct an 'Edinburgh Postnatal Depression Scale' screening. A high score on this test will prompt her to make a GP referral, after which she will follow-up on the patient's wellbeing.

"There are so many people who are vulnerable these days. If I see that someone is vulnerable, I will send them on to other supports like 'Parents First', which is a support group for parents, much like the community mother and toddler groups. People who are isolated, I would send them in to meet other mothers and to make a new community."

Ms Marteinsson is also a breastfeeding lactation consultant. Mothers outside her catchment area, who are experiencing issues with breastfeeding, are referred to her for assistance by other nurses.

Like other PHNs, Ms Marteinsson can be a lifeline for people in financial crisis in her community. "If there are people who are in difficulty, I'd refer them to St Vincent de Paul, or go to the community welfare officer for a pram or a cot if they need it. I'd do the Child Safety Awareness Programme checks to see if people have the right car seats for their children, the right stair guards and fire guards if needed."

Often, the simple caring presence of a PHN can be a huge comfort for patients.

"I'll listen to what's going on and see if I can help. I'm seen, I suppose, as the friendly ear for everybody," said Ms Marteinsson. "I try to build up good working relationships with the families and they know that they can trust me."

Misunderstood

Ms Marteinsson feels that the CFSA, HSE, and people in general, have a misunderstanding about the role of the PHN, but she believes that PHNs could still play a significant role in the CFSA.

"I hope the agency will allow the PHN to still have a child and family health load and be autonomous in that respect, while also having a colleague, who is in a specialist area, working with certain families that are in severe difficulties.

"The whole idea is trying to prevent a problem before it occurs. We try to stop problems developing and that's why, right from the beginning, when I teach the antenatal classes, I advertise the free services that are available and I encourage people to attend. If I see someone who is vulnerable, I would seek to get them engaged with the community resources that are there."

She said: "The babies of mothers who are depressed are less likely to smile, so that affects their development as well, so it's about teaching the parents to react with their child in a positive manner until they can really do it spontaneously."

"Depression also affects the activities the mother does with the child and social integration. The community will be able to help them, but if they're behind closed doors and they're not interacting at all, they're becoming more and more isolated."

Job satisfaction

Ms Marteinsson asserts that the job of the PHN is not easy, but witnessing progression in her patients as a result of her work is very satisfying. The positive feedback she receives from the families she works with is also very rewarding. "People say to me that I do make a difference," she said.

However, time restrictions can be frustrating for her and other PHNs around the country.

"Sometimes you have to be in many places at the same time," said Ms Marteinsson. "If somebody comes into me and they're in trouble, it means you have to drop everything else and concentrate on them and give them your undivided attention."

"There are fewer of us on the ground than there used to be, so I've to do more with less."

The ever-increasing scope of practice also exerts extra pressure on the PHN. "We're now doing postnatal listening visits, which means that I have to go to a mum and see her for an hour over a six-week period. If I've five ladies in my area that's five hours a week that's gone out of my working hours. I will do it, but it's very hard sometimes."

With more than 500 children on her caseload, she can sometimes feel overwhelmed. "It's a case of balancing all of the time. Sometimes you make the right choice and sometimes you don't. And sometimes people don't understand. They're not being selfish, they just don't see the fact that there's not only them," Ms Marteinsson said. "I can only do my best."

The role of the PHN has changed considerably with regards to the report writing and paperwork that must be completed.

"The amount of paperwork compared to the old days when I just used to go out and care for people and nobody would complain!" said Ms Marteinsson. "The paperwork is something that I'm not particularly fond of, but it's something that has to be done."

She would like more administrative support for PHNs with tasks like documentation and appointment scheduling, so that they could have more time to spend on their clinical duties.

Continuous professional development

Like many of her colleagues around the country, Ms Marteinsson feels that there is a shortage in the resources being allocated to PHNs. This lack of resources is preventing community nurses from delivering their full skills, knowledge and competencies.

"I also used to be involved in the Institute of Community Health Nursing, as the chair of the population health interest group, but I'm not being released to go to the meetings anymore."

Patricia Marteinsson is a public health nurse in Offaly and is also chairperson of the public health nurse (PHN) Section of the INMO

The Offaly nurse says that PHNs have little opportunity to engage in continuous professional development due to constraints in time and funding.

"They just don't seem to have the resources available to release people, so any continuing education I'll be doing, I'll be doing on my own time."

Ms Marteinsson has signed up for a psychology diploma course online, which she is funding herself. She is a qualified infant massage instructor and up until last year, utilised this qualification in her capacity as a PHN. However, she was recently forced to cease this work in order to provide services on the frontline.

Dwindling numbers

Ms Marteinsson is concerned about the shortage of PHNs in communities nationwide, and the failure of the HSE to provide adequate training places for PHNs in the future – there are just 40 places available this year.

"If they strip the PHNs down to the bare minimum there will be more and more social work cases coming to light," she said.

"I know in the present climate there are cutbacks and they have reduced the number of PHNs on the ground. The new PHNs that they're training are not guaranteed a position. The number that are retiring have far exceeded the number that's been recruited."

"In England they realised that by stripping the health visitors off the ground, they were creating more difficulties and creating more cases for the social work department. PHNs are worth their weight in gold."

– Gillian Tsoi