



Improving the effectiveness of the link system in an acute trust

- The matron from the Directorate of Medicine for Older People;
- The head of training and development;
- Senior sisters representing medicine, surgery, paediatrics and the high-dependency unit.

The three CNSs on the committee agreed to conduct a literature search to look at experiences of other hospitals regarding the role of the link person. Unpublished literature from work in our own hospital regarding a contract for link staff was also evaluated.

Literature review

A look at the history of the CNS and link person enabled the group to consider problems encountered by others in the past to avoid 'reinventing the wheel'. A rigorous literature search revealed a small number of previous studies, published between the early 1980s and 2003.

The term 'clinical nurse specialist' began to appear in the mid-1960s. By the early 1970s it was clear that a way of developing the role within a wider context was needed. According to Hamric (1989) and Charalambous (1995), CNSs were developing their individual knowledge at the risk of de-skilling ward staff, so a system was needed to disseminate information and educate ward staff. This view was also highlighted by Mallison (1984), who looked at the development of the CNS role. The idea that CNSs could involve other nurses in general ward areas to assist in education and provide a climate of change based on evidence-based practice was relatively new in the early 1980s.

By 1983 there were suggestions (Fife and Lemler, 1983) that CNSs could identify one key nurse who would be responsible for updating colleagues in their own areas of practice. The key nurse could also identify weak areas or issues that needed addressing and communicate these to the CNS. Fife and Lemler (1983) suggested CNSs could use their position to form strong bonds with key nurses to further enhance this 'two-way street' approach.

According to Tinley (2000) this collaborative approach only improved patient care. Having a link person promoting each specialty within every clinical area appeared ideal. However, the problems identified earlier often proved to be a barrier.

Options for a solution

Having discussed the link system's problems at the first committee meeting, all members were asked to bring a suggested solution to the second. The committee decided to offer a complete list of specialties to each ward and ask them to choose their five most relevant. This would reduce the number of link staff needed, making it easier

to release staff for meetings and study days.

The committee's proposal was presented to a CNS meeting and was fully supported. However, some CNSs absent from the meeting objected strongly. They felt that essential core areas, such as moving and handling, may not be chosen by the wards but should be mandatory. The subject became controversial because CNSs could foresee a system they had admitted was not working being replaced by one that was even worse.

The committee looked for other options. The idea of grouping related specialist areas – such as nutrition, upper gastrointestinal and stoma care – and assigning one link person to manage each group was considered. However, this was also rejected by some CNSs. Another idea was to identify a small number of core areas applicable to all wards, each of which would require one mandatory link person. Link staff for other specialist areas not core to all wards, such as respiratory care, would be negotiated with each ward. Ward managers would be advised to keep extra link staff to a minimum.

The CNSs were given two options: to maintain the present system or to make the selected six identified core areas mandatory, then have extra link staff as needed.

The CNS voted for the second option. Further recommendations for disseminating information were also made, which could have been adopted regardless of which option the CNSs had selected.

Further recommendations

In most cases, instead of holding regular link meetings

BOX 1. THE MAIN PROBLEMS WITH LINK

- Link staff were unable to leave the wards to attend regular link meetings due to pressure of work and the proliferation of link areas.
- Even when staff were able to attend link meetings they did not disseminate information to fellow staff.
- Some staff had been asked by their managers to represent areas in which they had not declared any interest and therefore enthusiasm was low.
- Clinical nurse specialists were not communicating with each other about the study days for their specialist areas. As a result, there may be three in one week and none for several months. Ward managers were finding it difficult to release staff on this basis.

FIG 1. THE RESEARCH CYCLE



AUTHORS Lynn Grigg, BA, RGN, is lecturer/practitioner in pain management, Luton and Dunstable Hospital NHS Trust and University of Luton; Farida Parkar, RGN, is respiratory nurse specialist, Luton and Dunstable Hospital NHS Trust.

ABSTRACT Grigg, L., Parkar, P., (2004) Improving the effectiveness of the link system in an acute trust. *Nursing Times*; 100: 7, 32-34.

Link staff are a valuable asset to any ward area. They can disseminate information to their colleagues from the clinical nurse specialist, act as role models and identify strengths and weakness. However, many trusts are discovering that, although sound in theory, practice is quite different. Ward staff find it difficult to attend meetings due to pressures of work and those who can attend fail to pass on information. This study describes how a trust identified the problems of the link system and suggests a solution that may be helpful to others.

Like many other trusts, Luton and Dunstable Hospital NHS Trust, a large district general hospital, operates a link-staff system to disseminate information from clinical nurse specialists (CNSs) to ward staff. If the system operates effectively, link staff (the term 'link nurse' was not used as it excludes non-nursing staff) can also act as role models and identify areas of strength and weakness.

Rationale

The trust's CNSs and nurse practitioners (NPs) meet regularly to update each other on relevant issues relating to specialties outside their own areas and discussing general trust matters. In January 2003 the link system was discussed because it was felt generally that it was not working. Link staff were failing to attend meetings, and the few who did were not disseminating information to colleagues. Since this was seen as the main purpose of the link system, CNSs were questioning its viability.

It was agreed that the effort involved in setting up and planning meetings was not worthwhile for the few staff attending. Releasing ward staff for short periods during shifts had been an increasing problem for ward managers because of staff shortages and increased patient throughput. Ward managers suggested it was easier to release staff for whole days as they could then arrange off duty accord-

ingly.

Study purpose and design

The study had two purposes:

- To clarify and evaluate the role of the link person;
- To investigate the viability of alternative methods of disseminating information from CNSs to ward staff.

An action-research approach to the study – as described by Lewin (1952) – was chosen because of the ongoing nature of the problem.

The research was investigative and ideas were developed along a continuum of meetings and negotiation with the CNSs. Two options were offered to them, a final vote was taken, results were collated and evaluated and subsequent decisions were made. A cyclical method was used in the problem-solving process (Fig 1) and recommendations for re-evaluation and future change were made.

Problems with the link system have been well documented at other hospitals (Charalambous, 1995), yet the majority of studies appear to give positive reports, including Horton (1988). Dawson's (2003) study looked at the role of the link person in relation to infection control, yet discussed some issues relevant to any specialty. Tinley (2000) presented a positive account of the link person in tissue viability.

However, few articles have studied the link system as a whole and suggested ways of managing it across a trust. The proliferation of CNSs has increased demand for link staff and it is suggested that no ward could support a link person for every specialist area. Disseminating information has traditionally been problematic (Collins and Robinson, 1996; Ching and Seto, 1990). McKenna (1995) suggests nurses are particularly poor at passing on information to colleagues.

This study identified a number of problems (Box 1). An area loosely related to the link-staff problem concerned specialist study days, for which no rolling programme had been organised. This meant CNSs were not working together to present a cohesive programme, resulting in many study days, sometimes in the same week. This made it difficult for ward managers to allocate staff to attend. It was felt that combining some areas, such as respiratory care and cardiac care, would alleviate the problem by reducing the number of study days.

It was decided that the best way to move forward was to form a steering group that would investigate:

- Whether the link system had a future, and if so how it could be taken forward; or if not, what might replace it;
- How study days could be organised in a more cohesive way throughout the trust.

The steering group originally consisted of three CNSs, but they decided to expand it to include staff with a wide range of knowledge and relevant expertise. This would enable them to obtain a diversity of opinions, provide inspiration and gain credibility. This larger group met six times, after which a further nine staff members and three CNSs from the steering group formed a committee. Committee members included:

- The head of nursing practice;

REFERENCES

- Charalambous, L. (1995) Development of the link-nurse role in clinical settings. *Nursing Times*; 91: 11, 36-37.
- Ching, T.Y., Seto, W.H. (1990) Evaluating the efficacy of the infection control liaison nurse in the hospital. *Journal of Advanced Nursing*; 15: 10, 1126-1131.
- Collins, M., Robinson, D. (1996) Bridging the research-practice gap: the role of the link nurse. *Nursing Standard*; 10: 25, 44-46.
- Dawson, S.J. (2003) The role of the infection control link nurse. *Journal of Hospital Infection*; 54: 4, 251-257.
- Fife, B., Lemler, S. (1983) The psychiatric nurse specialist: a valuable asset in the general hospital. *Journal of Nursing Administration*; 13: 4, 14-17.
- Hamric, A. (1989) Role development and function in: Hamric, A.B., Spross, J. (eds) *The Clinical Nurse Specialist in Theory and Practice*. New York, NY: WB Saunders.

This article has been double-blind peer-reviewed.

For related articles on this subject and links to relevant websites see www.nursingtimes.net

REFERENCES

Horton, R. (1988) Linking the chain. *Nursing Times*; 84: 26, 44-46.

Lewin, K. (1952) In: Cartright, D. (ed) *Field Theory in Social Science: Selected Theoretical Papers*. London: Tavistock Publications.

Mallison, M. (1984) The shoes of the clinician. *American Journal of Nursing*; 84: 587.

McKenna, H.P. (1995) Dissemination and application of mental health nursing research. *British Journal of Nursing*; 4: 21, 1257-1263.

Tinley, P. (2000) The link nurse system in relation to the speciality of tissue viability. *British Journal of Nursing*; 9: 19, S59-S62.

FIG 2. THE TRIPARTITE CONTRACT

MANAGER	LINK PERSON	CLINICAL NURSE SPECIALIST
<ul style="list-style-type: none"> ● Appoint link person(s). ● Allocate time to attend study day(s) and meetings. ● Ensure personal development plan includes activities related to link person's sphere of care. ● Support link person and CNS in developing practice in related sphere. ● Ensure replacement if link person leaves ward area and notify relevant CNS and the central list holder. 	<ul style="list-style-type: none"> ● Attend and participate in link study day(s). ● Send apologies if unable to attend. ● Disseminate new information to all staff after study days. ● Formulate and develop educational resources in own area environment (such as key papers, books, display board). ● Identify personal learning needs related to link sphere and use personal development plan to identify learning strategies. ● Participate in practice development in own environment (for example, comment on draft guidance documents; ensure resources are available; monitor practice). ● Inform ward manager and CNS of concerns related to sphere of practice. 	<ul style="list-style-type: none"> ● Provide information for new link people. ● Develop communication systems to facilitate the sharing of information (such as newsletters). ● Maintain accurate records of documentation of all information given to link person and ward manager. ● Offer educational opportunities for link staff. ● Disseminate research findings and advise on relevance to practice. ● Involve link staff in practice development initiatives. ● Assist link staff with their personal development plans. ● Act as mentor for link staff undertaking related education.

that the onus could be on the CNS to make contact. This could be via newsletter or personal contact. All contacts should be recorded and the ward manager informed. A copy of communications between the CNSs and link staff should be available for all staff to read, and signed when read. Meetings could be held in addition to this, at the discretion of the CNSs. To alleviate pressures on link staff, health care assistants (HCAs) could be appointed as associate link staff if they wished to.

Display boards could be available for each ward area, to be used in turn by each specialist area for one month following the relevant study day. Each CNS would plan and organise one or two study days per year, with an annual plan circulated to all link staff and ward managers. Colour-coded folders would be provided to each ward to contain copies of all communication between CNSs and link staff. All past display-board material would be filed in the folders to act as a resource.

Occupational therapists, physiotherapists, pharmacists and speech and language therapist teams would be included and could provide their own link staff. It would be the responsibility of the link leads to ensure they were invited to relevant study days and link meetings.

Link staff, ward managers and CNSs could be asked to sign a tripartite contract setting out the responsibilities of each with regard to the link system (Fig 2).

Implementation plan

An implementation plan was agreed upon, to begin in January 2004. The original three CNSs would inform all ward managers, senior nurses and link nurses about the

link person for each of the core areas and a current list of all link nurses would be held centrally and updated regularly. It would be the responsibility of each signatory of the contract to notify the list holder if the link person planned to change post or relinquish the role.

Experience so far

At the time of writing, most wards have implemented the new system and the first study day has already taken place. The authors are listing all link staff and their specialties and plan to visit wards to find out if they have any problems. The link person contract is being reviewed as a result of the feedback from workshops.

Most CNSs have started to use a newsletter rather than meetings as the main means of communication. However, the main change since the new system was implemented is in the ethos and culture surrounding the role of link person. Its profile has been raised and staff appear to be taking its function far more seriously.

Conclusion

This study has highlighted some of the recent problems encountered with the link system. While the concept of disseminating research and up-to-date information via a link system is sound, its practice is sometimes ineffective. Much has changed in recent years and this investigation showed it was time to redesign the system.

The success of the new system depends on the CNSs, as much of the responsibility has shifted to them from link staff. Only time will tell whether the changes recommended in this article are workable. However, at this