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# Independent evaluation of the nurse-led ACT Health Walk-in Centre

Australian Primary Health Care Research Institute  
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## Abbreviations

ACT	Australian Capital Territory
ACTDGP	ACT Division of General Practice
ACT AMA	Australian Medical Association, ACT Branch
ADON	Assistant Director of Nursing
ANU	The Australian National University
APHCRI	Australian Primary Health Care Research Institute
BEACH	Bettering the Evaluation And Care of Health
CALMS	Canberra After Hours Medical Service
CATT	Crisis Assessment Treatment Team
CDSS	Clinical Decision Support Software
CNC	Clinical Nurse Consultant
ED	Emergency Department
DON	Director of Nursing
FPA_PHC	Framework for Performance Assessment in Primary Health Care
GP	General Practitioner
HCCA	Health Care Consumers' Association of the ACT
IWS	Index of Work Satisfaction
NHS	National Health Service
NSW	New South Wales
NT	Northern Territory
QLD	Queensland
SA	South Australia
TAS	Tasmania
TCH	The Canberra Hospital
UK	United Kingdom
URTI	Upper Respiratory Tract Infection
VIC	Victoria
WA	Western Australia
WiC	Walk-in Centre



## Executive Summary

The APHCRI evaluation of the ACT Health Walk-in Centre was conducted between May 2010 and May 2011. The evaluation included seven stages of data collection, examining the structure, process and outcomes of the Walk-in Centre. These stages included:

- > An international literature review:
  - Desborough J, Forrest LE, Parker RM. (2011) Nurse-led primary health care walk-in centres: An integrative literature review. *Journal of Advanced Nursing*; In press (Accepted 26th May 2011)<sup>1</sup>
- > An audit of the Clinical Decision Support Software (CDSS) used at the Walk-in Centre (Chapter 2);
- > A patient satisfaction survey (Chapter 3);
- > A satisfaction survey and interview with the clinical nursing staff at the Walk-in Centre (Chapters 4 and 5);
- > Interviews with stakeholders of the Walk-in Centre (Chapter 6);
- > The impact of the Walk-in Centre on the workload of the ACT Emergency Departments (ED) (Chapter 7);
- > Costs and Cost Implications of the Activity of the Walk-in Centre (Chapter 8).

## AUDIT OF WALK-IN CENTRE DATA

The purpose of the audit was to examine the patterns of activity of the Walk-in Centre and to explore the nature of the client group. In doing so some data issues became apparent. The conclusions of the audit are:

### Activity

- > Activity levels were relatively stable through 2010 being around 1100 per month apart from an unexplained peak in November;
- > The first four months of 2011 showed a marked increase to levels between 1200 and 1400 per month;
- > While the number of Outbound<sup>1</sup> patients is relatively stable, the proportion is declining;
- > Waiting times declined over the first few months of operation of the Centre. More recently waiting times have depended on activity levels:
  - In the relatively quiet month of December 2010, the median waiting time was about 10 minutes, while in May 2011, which was busy it increased to 19 minutes;
  - Service times on the other hand after declining from the initial levels are relatively stable with median time of 35 minutes in May 2011;
- > Most patients arrive in normal business hours, with 9% arriving before 9am and 5% after 9 pm;
- > Monday is the busiest day and Saturday the quietest;
- > 63% of Inbound patients are treated in the Walk-in Centre with no need for further treatment;

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<sup>1</sup> Patients who are treated in the Walk-in Centre are referred to as “Inbound” and those who are referred on without assessment and treatment are referred to as “Outbound”.

- > 21% are redirected to GPs for further or follow-up treatment and 5% redirected to ED;
- > 1.7% of all patients leave before or during treatment.

### Patient characteristics

- > 89% of patients come from the ACT and 7% from surrounding areas of NSW;
- > ACT patients travel on average 7 km to the Centre with small numbers travelling more than 15 km;
- > The socio economic status mix of the patients is similar to that of the ACT community as a whole;
- > The majority of patients are working age, with 14% aged under 10, 18% aged 10-19 years and 8% of patients treated aged 60 years or over;
- > 54.2% of patients were female;
- > The most common conditions are respiratory (28%) which are predominantly coughs and colds, musculoskeletal (23%) which are a mix of trauma related and other problems, and skin (18.1%) which are a mix of wound and rash problems;

### Data issues

- > A number of data items collected are not available on the data extract (indigenous status, country of birth, initial intention, Inbound/Outbound) and would be useful if they were available;
- > Clinical conditions are reported at a fine level of detail, but there is no obvious hierarchy to enable them to be aggregated to broad categories;
- > All times are dependent on when staff entered activities into the computer – so in busy times patients may be in the waiting room for some time before their information is entered, nurses may sometimes open records and consider them before calling patients in (leading to shorter waiting times and longer service times than perceived by patients), and nurses sometimes do not complete records until some time after a patient has left.
- > The extreme of these situations arises where patients are sent for x-rays and records kept open while they are away – some results in this audit will differ from results from other analyses due to different management of very long wait times or service times.

## PATIENT SATISFACTION SURVEY

### Demographics

- > 246 completed surveys were returned (89% response rate);
- > Survey completed by:
  - 73% patients;
  - 22% parents of a child who was the patient;
  - 5% partners, children, other relatives or friends of the patient;
- > Age and gender of survey respondents representative of the whole Walk-in Centre population.

### Access

- > 30% were repeat attendees;

- > 94% travelled to the Walk-in Centre by car;
- > Location and opening hours were convenient;
- > Main reason for attending the Walk-in Centre was because it was quicker than getting an appointment with a GP (58%) and a shorter wait than that in ED (39%).

### Satisfaction

- > Respondents were satisfied with the Walk-in Centre in terms of:
  - Attitude of receptionist – 82% very satisfied;
  - Attitude of nurse – 89% very satisfied;
  - Explanation the nurse gave about their problem – 81% very satisfied;
  - Treatment or advice the nurse gave them – 80% very satisfied;
  - Length of time they spent with the nurse – 82% very satisfied;
  - Overall satisfaction with service at Walk-in Centre – 79% very satisfied;
- > Waiting time was the only factor that did not receive a majority of very satisfied:
  - 37% fairly satisfied and 42% very satisfied;
  - This has implications for the service in the future if it gets busier and patients are required to wait longer;
- > 84% would definitely recommend the Walk-in Centre to family and friends and 82% would definitely use the Walk-in Centre again.

## WALK-IN CENTRE NURSE SATISFACTION: INDEX OF WORK SATISFACTION SURVEY

The Index of Work Satisfaction (IWS) is a validated measurement tool designed to assess nurses' satisfaction with their workplace. The IWS was used to assess the clinical nursing staff's satisfaction with their workplace using six components:

- > Pay;
- > Autonomy;
- > Task requirements;
- > Organisation policies;
- > Professional status;
- > Interaction.

The nurses compared and ranked each component to determine which component was the most important. They ranked autonomy as the most important and pay as the least important component of satisfaction.

The nurses scored attitude statements from strongly agree to strongly disagree to determine their satisfaction with each component. The mean score for each component (range = 1 – 7) indicated that the nurses were most satisfied with their professional status (5.50) and least satisfied with the organisational policies (2.60) of the ACT Health Walk-in Centre.

The importance ranking and satisfaction score were combined to give an overall satisfaction score. This demonstrated that the nurses perceive that their professional status (19.80) and autonomy (17.38) are the most important and most satisfying aspects of their role, and the organisational policies (6.76) are the least important and least satisfying aspects.

## WALK-IN CENTRE NURSE SATISFACTION: QUALITATIVE INTERVIEWS

Sources of dissatisfaction are reported mostly in relation barriers to accessing ongoing education and, for some, a perceived lack of ability to contribute to the running of the centre. The initial preparatory training program for the Walk-in Centre nurses and training for new employees were considered inadequate. The absence of relief staff impacts the nursing staffs' capacity to access leave and opportunities for professional development. For current and prospective nurse practitioners there is a sense of role ambiguity and the absence of an available career structure or organisational mobility within the walk-in centre.

Sources of satisfaction are expressed in relation to autonomy, the ability to provide quality nursing care, a manageable workload and relationships within the team.

Most nurses identified significant difficulties with the Clinical Decision Support Software (CDSS). Although some saw it as a 'safety net', the CDSS process is seen as cumbersome and time consuming. Furthermore, the process for updating protocols was lengthy and unsatisfactory.

## INTERVIEWS WITH STAKEHOLDERS OF THE WALK-IN CENTRE

### Physical facilities and equipment

Most stakeholders had not visited the Walk-in Centre; those who had were satisfied with the physical layout. Some concerns were raised in regard to patient privacy when talking with reception staff.

### Human Resource Management

#### *Staff education and training*

There was general concern with the provision of training and ongoing education for Walk-in Centre staff. In particular, stakeholders involved in the initial training for Walk-in Centre staff voiced significant concern in regard to the provision of training for new staff, which some perceived to be non-existent.

The need for ongoing professional development was identified, in particular for nurse practitioners. The one remaining nurse practitioner provides a source of education and mentorship for the advanced practice nurses (when he is on shift); however the provision of education and mentorship for the nurse practitioner was considered inadequate.

### Information Systems

#### *Clinical Decision Support Software (CDSS)*

The CDSS was identified as problematic for a number of reasons:

- > It is a standalone system, which cannot interface with other systems within ACT Health or The Canberra Hospital; duplicate registrations and manual faxing of reports are required to negotiate this;
- > The cumbersome nature of the protocols;
- > The capacity for the software to generate reports, such as medication administration and supply. Other manual systems have been required to record this information within the Walk-in Centre.

## Service organisation and management

### *Model of care*

Most stakeholders were satisfied with the nurse-led model of care; however all but two believed that in order for this model to be successful, the scope of practice of the advanced practice nurses needs to be extended. Most believed that the nurse practitioners need to be supported to fully implement their roles; however a few believed the model can be successful without nurse practitioners.

The ACT Division of General Practice (ACTDGP) and the ACT branch of the Australian Medical Association (ACT AMA) believed that the nurse-led model of care is a 'silo' approach to health care, which is contrary to current and future projections for primary health care to have a multi-disciplinary approach.

### *Alternative models of care*

A number of stakeholders believed the model of care could be enhanced with the inclusion of a doctor, providing a source of collaboration, mentorship and referral for patients who fall outside of the scope of nursing practice. Some envisioned a future where one doctor could provide this support across a number of Walk-in Centres.

Two stakeholders referred to the potential of a physiotherapist included in the model of care.

## Processes of care provided

### *Protocols*

The use of protocols as integral to the model of care was identified as problematic to most stakeholders. A number of issues were raised, central to these is the fact that adherence to the protocols prevents the nurses from utilising their clinical decision making skills and scope of practice, significantly limiting the scope and quality of care provided at the Walk-in Centre. There is general support for the use of protocols and standard operating procedures in collaboration with the clinical decision-making capacity of the nurses.

### *Referrals*

A significant source of dissatisfaction for emergency department (ED) staff was related to referrals from and to the Walk-in Centre. Often when triage staff refer patients to the Walk-in Centre, these patients are re-directed back to ED, often referred to as double-handling. There was a perception that a large number of patients are referred from the Walk-in Centre to ED, leading to an increase in patient numbers and subsequent pressure on ED; however, this was perceived to have decreased over time.

### *Quality of care*

Most stakeholders' comments regarding quality of care were anecdotal; however one had attended three times with family members as patients and stated that the quality of care was excellent.

## Access to Primary Care

Most stakeholders were not supportive of the current location of the Walk-in Centre. A number of reasons were given to support these opinions:

- > People requiring primary care services are inadvertently brought to a tertiary care campus, often resulting in inappropriate attendance at the ED;
- > The Walk-in Centre should be located in areas where the need for primary care services has been identified, such as those where general practice services are known to be inadequate.

Suggestions were also made in terms of alternative models of care for Walk-in Centres in different locations; the Walk-in Centre at The Canberra Hospital operating with advanced practice nurses, whilst those in community locations operate with nurse practitioners as well as advanced practice nurses.

### Inter-provider agency networks and relationships

#### *Organisational input into the Walk-in Centre*

Most stakeholders believed that their organisations have had ample opportunity to have input into the development and ongoing operation of the Walk-in Centre. The ACTDGP and the ACT AMA are dissatisfied with the level of their involvement in initial consultations regarding the Walk-in Centre. They also stated that they have no relationship with the staff or management from the Walk-in Centre and have not been contacted since its opening.

#### *Community perception of the Walk-in Centre*

Most stakeholders believed that those in the community who are aware of the Walk-in Centre are supportive of it; consumer representatives stated that there is overwhelming support for it. However there is a significant perception that the community has not been adequately informed. A number of stakeholders believe ongoing and improved marketing could improve public awareness of the Walk-in Centre.

## THE IMPACT OF THE ACT HEALTH WALK-IN CENTRE ON ACT EMERGENCY DEPARTMENT WORKLOADS

One objective of the Centre was to reduce demand on the emergency department (ED) at The Canberra Hospital (TCH). Analysis of ED trends is difficult due to the volatile patterns, but suggests:

- > That numbers of triage category 4 and 5 services at the TCH-ED increased materially above trend levels during the first 12 months of operation of the Centre;
- > During the same period the triage category 4 and 5 services at the Calvary Hospital ED appear to have declined relative to trend.

An alternative analysis is based on information from the Walk-in Centre on the source of their patients, where the patients say they would have gone in the absence of the Walk-in Centre, and where patients are directed from the Walk-in Centre if further services are required. The net results of this analysis depend on the assumptions taken, however:

- > In relation to Inbound patients, the Centre prevents more patients from going to ED than it refers;
- > In relation to Outbound patients, there are a substantial number who are referred to the ED who are unlikely to have otherwise gone to the ED;
- > The net effect of the Inbound and Outbound patients on the ED can vary widely depending on a range of assumptions including:
  - o How many Outbound patients attending the ED would otherwise have gone to the ED;
  - o How well Inbound patients identify where they would have gone in the absence of the Walk-in Centre;
- > The most likely result is that the overall impact is a net increase in ED activity due to the Walk-in Centre.

## COSTS AND COST IMPLICATIONS OF THE ACTIVITY OF THE WALK-IN CENTRE

As the health benefits of the Walk-in Centre's services (and comparable services provided by ED and GP providers) cannot be measured, the cost analysis must be based on costs per service.

Taking a direct costing approach:

- > The average cost per service provided by the Walk-in Centre in the first 12 months of operation of the Centre was \$196;
- > If the Walk-in Centre was operating at its notional maximum level of 80 services per day every day this would fall to \$114;
- > As activity levels increase over time the actual cost will fall between these two extremes;
- > All these values fall between the average costs of an ED service in triage category 4 or 5 of \$281 and the average cost of a GP service of \$45.

If a wider perspective is taken, where:

- > The costs of GP services saved or generated by the Walk-in Centre are included;
- > The costs of additional or reduced ED services are included (noting that in practice ED total costs tend to be stable unless there is a major change in demand);
- > Then a range of different average costs per service in the Walk-in Centre may be derived. These all however range between \$116 and \$196, leading to the same broad conclusion that the Walk-in Centre costs are between the ED and GP costs;
- > Whether services provided at these costs provide value for money is a matter of judgment, to be made in the context that if the Walk-in Centre was not present the services would either not be provided, or would be provided at a later date, both of which have potential health consequences for patients.





# Chapter 1 Introduction

## BACKGROUND

### Improving access to primary care

In common with other areas of rural and regional Australia, the Australian Capital Territory (ACT) is currently experiencing a general practitioner (GP) workforce shortage which impacts significantly on the ability of patients to access GP led primary care services. While there have been a range of strategies developed to attract more GPs to the ACT,<sup>2</sup> innovative models of care, including the use of nurses to provide primary care services, have also been developed in response to this shortage.

The introduction of a nurse-led primary care Walk-in Centre in the ACT in May 2010 is one such initiative. This model of care has been implemented extensively throughout the United Kingdom (UK) since 2000 and has been the subject of a national evaluation in the UK.<sup>3</sup>

### Primary care in the ACT

The Australian Capital Territory (ACT) has 235 full time workload equivalent (FWE) GPs servicing a population of 358,900, which is one of the highest patient to GP ratios in Australia.<sup>4</sup> General practice services are provided in private practice with the Australian government providing insurance to patients. This means to a large degree, general practice services are funded by the Australian government, although general practitioners can charge patients above the amount refunded by the government so that patients are required to pay a 'gap' payment. States and territories also provide primary care services which are usually provided free.

Nurse-led Walk-in Centres in the UK have been established since 2000 and evidence of their operation and outcomes has been demonstrated through a national evaluation which was completed in 2002.<sup>3</sup> This national evaluation aimed to determine whether the Walk-in Centres improved access to high quality care in a manner which is efficient and supports other National Health Service (NHS) providers.<sup>3</sup> Care provided at the UK based Walk-in Centres was demonstrated to be of high quality and comparable to primary care provided at general practices.<sup>5</sup>

The vision for the ACT Walk-in Centre was to complement, not replace, other primary care services.<sup>6</sup> The ACT Health nurse-led primary care Walk-in Centre was modelled on the Walk-in Centres in the UK. The Walk-in Centre is staffed solely by registered nurses. The Walk-in Centre is open from 7.00am until 11.00pm every day and provides walk-in access to acute and episodic care in accordance with clinical protocols without the need for an appointment.

### The Role of Nurses in the Provision of Primary care Services

The nursing role in delivering primary care services has been developing over the past decade in Australia and includes enrolled and registered nurses as well as nurse practitioners.<sup>7</sup> International evidence indicates that nurses working in primary care can provide effective care and achieve good patient compliance and positive health outcomes for patients, similar to that achieved by doctors.<sup>8</sup> Nurse practitioners employed in primary care perform some tasks which were previously exclusive to the GP role due to their advanced skills, knowledge and training.<sup>9-12</sup> These include making autonomous decisions regarding minor acute illness and injury, and management of some diagnosed chronic conditions.<sup>13</sup> International studies demonstrate that nurse practitioners working in primary care provide at least equal quality care to GPs and yield higher satisfaction among patients with no differences in health outcomes.<sup>14-17</sup> Nurse practitioners can therefore provide primary care to patients in underserved areas by being able to order diagnostic tests,

diagnosing common illnesses, prescribing selected medications and referring patients to other healthcare professionals where necessary.<sup>10,12,18,19</sup>

### Establishment of a Nurse-led Walk in Centre in the ACT

In 2008, the ACT government announced **Your health – our priority: ready for the future**, which marked the beginning of a 10 year redevelopment of health infrastructure in the ACT. This redevelopment included a number of new service initiatives, including a Walk-In Centre.

A feasibility study was conducted to investigate the potential to open a Walk-In Centre in the ACT. Three staff from ACT Health went on an observational tour of Walk-In Clinics in the United Kingdom in 2008. These were the Director of Health Performance Improvement, Innovation and Redesign, the Assistant Director of Nursing, Emergency Services, The Canberra Hospital and the GP Advisor to ACT Health.

This team inspected 10 sites in areas that were considered to closely resemble the ACT in size and demographics. These were Bristol, Bath and Exeter. There was variety in the location and model of care between sites, which included:

- > Shopfront;
- > Community health centre;
- > Co-located with general practice, pharmacy, café, out of hours medical service;
- > Co-located with a hospital ED;
- > On hospital grounds by apart from the ED;
- > Within a community hospital that does not have an ED.<sup>6</sup>

Further to this, a literature review was conducted to establish an evidence base for practice and an extensive consultation process took place. Community consultation included two community fora in December 2008 where comment and feedback was provided by 19 participants. Additionally, the paper, *Walk-In Centres in the ACT*, was distributed and interested parties invited to provide input or comment via the ACT Health website. Consultation occurred between ACT Health and major community stakeholders, including the Australian Medical Association (AMA) and the ACT Division of General Practice (ACTDGP). Formal responses were provided by:

- > ACT Division of General Practice;
- > ACT Health Emergency Care Network;
- > ACT Council of Social Service;
- > Anglicare, Canberra and Goulburn;
- > Australian College of Nurse Practitioners;
- > Australian Medical Association, ACT Branch;
- > Australian Nursing Federation, ACT Branch;
- > Calvary Health Care ACT;
- > Kambah Village Medical Practice;
- > Health Care Consumers Association;
- > Pharmacy Guild of Australia, ACT Branch;
- > Royal College of Nursing, Australia;
- > Society of Hospital Pharmacists, ACT Branch;
- > University of Canberra;
- > Valley Medical Centre;
- > West Belconnen Health Co-op Ltd.<sup>20</sup>

The vision for a Walk-In Centre in the ACT was that it could complement other primary care services. In particular, the initial discussion paper suggested it could:

- > Fill a niche between private practitioners (GPs, Canberra After hours Locum Medical Service (CALMS) and community pharmacy) and other government services (Emergency Departments, ACT Ambulance service and Health Direct);
- > Service areas of previous unmet need, which might be relevant to young people between 15 to 34 years, men, and people who attend EDs with minor conditions but do not wait for treatment;
- > Provide opportunistic health promotion to the above groups;
- > Supplement existing services in the event of public health incidents; and
- > Provide the community for greater health care choice.<sup>6</sup>

Different models of Walk-In Centre were provided for consultation, including location and model of care. Choices of location included:

- > Co-location with other providers such as GPs;
- > Co-location at a hospital with an ED;
- > Location in areas such as shopping centres, where there is a high volume of people and convenient access to public transport and/or parking.<sup>6</sup>

Models of care included:

- > GP-assisted model; a multidisciplinary team in an interdependent and co-operative relationship, structured around a GP providing complex medical care;
- > Nurse-led model; using advanced practice nurses (RN 3.1) or nurse practitioners (4.2) practicing autonomously;
- > Allied health professional collaborative model; incorporates Allied Health Professionals within the staffing model;
- > Physician Assistant model; utilises Physicians Assistants as the primary care providers. These are defined as non-autonomous, tertiary educated health professionals, licensed to practice under the supervision of a medical professional. This supervision can be provided from a distance.<sup>6</sup>

Potential challenges were identified in regard to:

- > Clinical staffing and associated workforce shortages;
- > Location in terms of maximising opportunities to provide appropriate health care;
- > Continuity of care; requirements for effective systems of referral and communication between the Walk-in Centre and other providers;
- > Scope of care;
- > Duplication of services and subsequent increased cost to the health sector;
- > Access to diagnostic services;
- > Professional resistance to a Walk-in Centre;
- > Safety; clinical protocols and robust governance structures;
- > Communications and marketing.

As a result of consultation, the decision was made to establish a Walk-In Centre on The Canberra Hospital campus, near to the Emergency Department. This was proposed to be the first of three for the ACT, with subsequent centres proposed for Gungahlin and Canberra City; establishment of these will be considered at a later date following establishment of the first centre.

The aims of the ACT Health Walk-in Centre were to:<sup>20</sup>

- > Fulfil an unmet health care need in the community;
- > Better meet projected demand for health care services;
- > Develop innovative strategies to recruit and retain a professional multidisciplinary workforce;
- > Relieve pressure on the public hospital system.

The niche for Walk-In Centres identified in the *Walk-In Centres Detailed Model of Care*<sup>20</sup> was between Health Direct and general practice. The model of care chosen was a nurse-led model, incorporating physiotherapists. During the development phase of the Walk-in Centre the role of physiotherapists was removed from the model of care for the initial Walk-in Centre.

### Staff structure in the ACT Health Walk-in Centre

Clinical nurses employed at the ACT Health Walk-in Centre are employed either as advanced practice nurses (RN 3.1) or as nurse practitioners (RN 4.2). In addition to these an Assistant Director of Nursing (ADON) (RN 4.3) is employed as the centre manager. The Operational Model of Care also included the future employment of a Clinical Nurse Consultant (CNC) (RN 3.2), when more walk-in centres were established. However, a Clinical Nurse Consultant was employed within the first 12 months of operation of the Walk-in Centre located at The Canberra Hospital. These nursing levels are classified in accordance with the *ACT Public Sector Nursing and Midwifery Enterprise Agreement 2010 - 2011*.<sup>21</sup>

## INDEPENDENT EVALUATION OF THE ACT HEALTH WALK-IN CENTRE

ACT Health engaged the Australian Primary Health Care Research Institute (APHCRI) at the Australian National University (ANU) to conduct an independent evaluation of the first twelve months of operation of the walk-in centre.

### Evaluation Framework

The framework for this evaluation is adapted from a conceptual framework for performance assessment in primary health care (FPA\_PHC).<sup>22</sup> This framework utilises Donabedian's quality of care framework linking structure, process and outcome.<sup>23</sup>

The stewardship function of this framework provides a background in terms of the policy, implementation and workforce development of the walk-in centre. This framework facilitates the capacity to draw links between policy, organisational structures, processes of care and patient outcomes; linking identified issues on one level to factors or processes on another level.

This framework highlights the importance of addressing organisational processes and processes of care separately. Firstly this enables identification and evaluation of organisational processes that do not involve patient care. Secondly, this separation provides a patient-focussed perspective, in addition to auditing data to determine the nature of services provided by staff.

### Quality, efficiency and equity

Assessment of **efficiency** relates to both time-efficiency and the cost effectiveness of the Walk-in Centre. The framework explores this through observing costs of implementation and ongoing organisational structure in relation to the processes of care and intermediate outcomes. Assessment of stewardship functions is also possible; however this is not within the terms of reference for this evaluation.

**Equity** is measured through assessment of processes of care and intermediate outcomes in terms of “is it the same for everyone?”<sup>22</sup> The evaluation was planned in accordance with the authors’ recommendation for a limit to the number of outcomes measures utilised, to avoid ‘reporting burden’ and at the same time to remain within the means available to the research team. Equity is measured in terms of processes of care received by patients, families and the community through observation of clinical audit and costs.

Achievement of **quality** is measured in terms of “specified targets for consumers”.<sup>22</sup> In regard to the Walk-in Centre these targets relate to patient satisfaction.

An additional measure of **efficiency** is the organisational structures of processes, measured through staff and stakeholder satisfaction.

A diagrammatic representation of the framework in its application to the evaluation of the Walk-in Centre is presented in Figure 1.

### Aim of the independent evaluation of the Walk-in Centre

This independent evaluation aims to examine the structure, processes and outcomes of the ACT Health Walk-in Centre for the 12 month period after opening on the 18<sup>th</sup> May 2010. This evaluation consisted of seven stages which each examine either the policy or operational side of the ACT Health Walk-in Centre. These stages include:

- > International literature review;
- > Audit of the Walk-in Centre data;
- > Patient satisfaction survey;
- > Walk-in Centre nursing staff: Index of Work Satisfaction survey;
- > Walk-in Centre nursing staff: Interviews about satisfaction;
- > Interviews with stakeholders of the Walk-in Centre;
- > The impact of the ACT Health Walk-in Centre on the ACT Emergency Department workload;
- > Cost and cost implications of the activity of the Walk-in Centre.

The international literature review has been accepted for publication by the International Journal of Advanced Nursing and is currently under embargo by the journal pending publication. Therefore, the findings of the literature review have not been able to be included in this report, but a copy of the publication will be circulated to ACT Health once published.

### Reference group

A reference group was established to oversee the methodology and to provide critical advice throughout the term of the project. The reference group comprised representatives from ACT Health, the Health Care Consumers’ Association of the ACT, the Royal College of Nursing Australia, General Practice and Primary Health Care at The University of Melbourne, and the Australian Primary Health Care Research Institute (Appendix K). The reference group met bi-monthly and the terms of reference were to:

1. Provide input on project methodology
2. Provide support for the study through dissemination of information when necessary
3. Provide critical advice throughout the term of the project

Figure 1: Framework for the evaluation of the ACT Health Walk-In Centre. Adapted from A Conceptual Framework for Performance Assessment in Primary Health Care, 2007

<b>ACT Health (policy/strategy)</b>	<b>ACT Health Walk-In Centre (operational)</b>		
	<b>Assessment of efficiency – relationships between costs and intermediate health outcomes</b>		
		<b>Assessment of Equity – “Is it the same for everyone?”</b>	
<b>1. Stewardship</b>	<b>2. Organisational structures and processes</b>	<b>3. Processes of care received by patients, families and communities</b>	<b>4. Intermediate outcomes for patients, families and communities</b>
Background Policy development Financing and funding Implementation Workforce Development Research & Development	Nursing staff satisfaction - satisfaction survey - face-to-face interviews Stakeholder satisfaction - face-to-face interviews	Clinical Audit Costs	Satisfaction with care in patient populations - patient satisfaction survey

## Chapter 2 Audit of the Walk-in Centre Data

### BACKGROUND

The ACT Walk-in Centre was opened in May 2010 and provides nurse-led primary care to the ACT community. Services provided by the Walk-in Centre are free. Services are limited by a set of protocols which define the services the Walk-in Centre may provide. There is a very limited formulary and limited range of pharmaceuticals available on site. A major boundary is that treatment of children aged under 2 years is not provided. The nature of the Walk-in Centre is that generally patients should only attend once for any episode of illness, and if it is not completely treated in that attendance they should seek further treatment in general practice or other locations depending on the condition. The main exception to this rule relates to fractures where multiple visits are appropriate.

This initial audit uses administrative data from the Walk-in Centre to explore the growth of the Walk-in Centre, the nature of the client group, and the nature of the services provided. We firstly discuss the actual data structures and some gaps in the data.

### ANALYSIS OF ADMINISTRATIVE DATA

Ethics approval to access the administrative data and the Clinical Decision Support Software data from the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.10.382) on the 24<sup>th</sup> November 2010 and subsequently given expedited approval by The Australian National University Human Research Ethics Committee on the 6<sup>th</sup> December 2010 (protocol no. 2010/622).

#### Data Sources

When patients arrive at the Walk-in Centre:

- > They are spoken to by the receptionist who makes a judgement as to whether they are in scope in which case they are asked to register, out of scope in which case advice is given on the most appropriate alternative providers of care, or if the receptionist is not able to make the judgement a nurse is called to decide whether the patient should be treated or referred elsewhere:
  - Those who are to be treated in the Walk-in Centre are referred to as “Inbound”;
  - Those who are referred on without assessment and treatment are referred to as “Outbound”
    - Outbound patients are added to the data base by the receptionist who assesses their gender, their approximate age, their condition (if this has been reported), and to whom they have been referred
- > Patients who are Inbound are asked to register by completing an admission form, the data from which is entered into the system by the receptionist.
- > When the patients are seen by the nurse, more information is entered on their condition and treatment, and whether they have been referred on to other providers for further treatment.
- > The data set also contains information on time of initial registration for all, and for the Inbound the time treatment commences and concludes.

The data used in analysis of the administrative data covers the period 18 May 2010 to 17 May 2011, the first 12 months of operation of the Walk-in Centre.



The Inbound and Outbound groups have different data sets and need to be considered somewhat differently. In the following analysis they are directly compared where appropriate (e.g. in looking at the patterns of service over time, but considered separately for some other purposes.) Unfortunately, the main issue for Outbound patients is the reason they are out of scope and this is not specified in the data set. Information is available on the reason they were present and in some cases why they were referred on but this is all in text form which can only be classified by detailed reading of a very large number of entries which has not proved practical.

There are two sources of the data:

- > A data extract from the full data base which does not include name and address, but includes age/gender/condition/treatment outcome and all the relevant time of treatment information.
  - This data set does not include indigenous status or country of birth, which are entered to the system but are not available to ACT Health after data entry
  - The data set does not include Inbound/Outbound status, which can be approximated either by non-zero treatment time, or by whether a nurse is identified as the “treating nurse”
    - The latter is used in this study, and it is understood these approximations are very close to the actual Inbound/Outbound classification
    - The total figures on this basis are quite close to those in the KPI reports for the Walk-in Centre
- > A series of reports which the Walk-in Centre staff may extract from the data base
  - There is no formal standard reporting, but using a somewhat rigid set of reporting structures data on specified variables can be selected for specified time periods
  - Walk-in Centre staff have kindly provided a range of these tables on request from the evaluator.
  - These reports do include some Inbound/Outbound data, but do not include and data on indigenous status or country of birth.

The Walk-in Centre also provides regular reports on their KPIs to the ACT Department of Health, and these reports have also been drawn on in preparing this audit.

### Comment on data issues

There is only one obvious piece of information which would have been valuable to the audit which is not collected, but there are several pieces of information collected which are either not readily available or not readily used. The missing information is the reason for considering patients “Outbound” and the data item which classified these people would be very useful in developing an understanding of which groups attend the Walk-in Centre who are not able to be assisted. While some information about the Outbound patients is collected in text form, none is collected in a classified form.

As noted above, indigenous status and country of birth are collected and the data entered into the data base, but the information is not available in either the data extract or in any of the structured reports. Indeed, not even the staff of the Walk-in Centre are able to access this data directly from the data base once it has been entered. This restriction provides a major limitation to studies of equity of access to the Walk-in Centre.

The lack of the Inbound/Outbound categorisation on the data extract means approximations are required, leading to some (fortunately small) differences between estimates based on



the extracts and those based on the structured reports. This information should be included in the data extracts.

Information is collected and entered into the data base on the patients “original inclination” – where they would have gone in the absence of the Walk-in Centre. This should be available in the data extract to assist in analysis of the impact of the Walk-in Centre on other service providers.

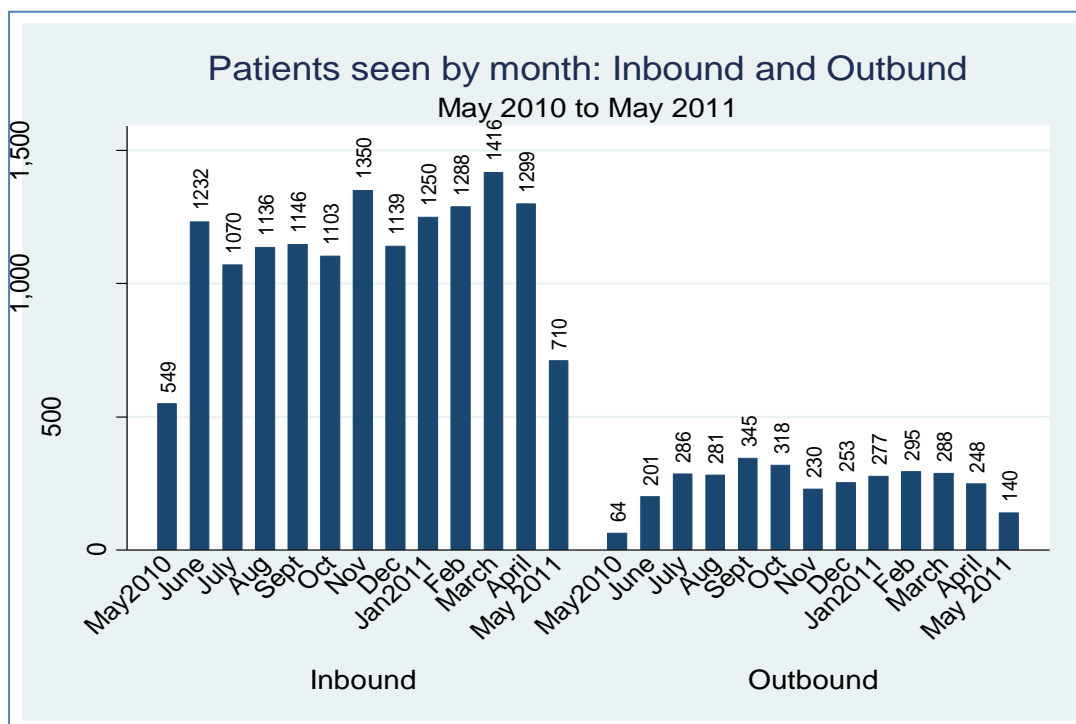
The condition coding by the nurses is very detailed (which is appropriate for a system which manages the treatment protocol) but there is no hierarchy which enables ready compilation of simpler tables. The final condition variables, for example, show a wide range of respiratory conditions but there is no automated way to combine these through a coding system.

The data does not appear to have been edited, and some times in particular are not plausible. There are apparently negative service times (generally very small times) which have been treated as zeros. There are also some extremely long waiting times (where the patient has been sent away for some days and returns – perhaps with an X-ray) which are not meaningful and which can have an influence the averages. In this analysis these very long treatment or waiting times have either been deleted or adjusted to more plausible levels. As the numbers of the extreme values are small they have little influence on median times, but they can have major impacts on estimates of mean waiting times or mean treatment times.

The times perceived by patients and those recorded will differ as they depend on when the receptionist enters the patient information into the system, when the nurse opens the file, and when the nurse completes their notes and closes the file. For a variety of reasons these times may vary from the patient arrival time, the time the patient is called, and the time the patient leaves.

### The growth of the Walk-in Centre

Figure 2: Patients seen in first 12 months of operation



Activity in the Walk-in Centre grew rapidly from its commencement in mid May 2010 to a relatively stable level across 2010 with an increase to a higher level in the early months of

2011. The monthly activity peaked in November and again in March for no immediately obvious reason.

The pattern of Outbound services appears to have peaked in September and then declined, and although it has increased again in 2011 has not reached earlier levels. As Outbound services reflect patients who have misunderstood the scope of the Walk-in Centre, the decline suggests that this problem may have been reduced.

*Data Note: These numbers are drawn from the data extract. They differ from the data in the reports in that the reports show almost no Outbound activity in May and June 2010 due to data problems at that time.*

### Waiting times and service times

Waiting times for Inbound patients treated in the Walk-in Centre declined over the early life of the Walk-in Centre as staff became more familiar with the systems. From September waiting times have largely reflected activity levels, with longer waiting times in months with higher activity. While median waiting times were 10-12 minutes by the end of 2010, with the increased activity levels in 2011 they have increased to 19 minutes by May 2011.

Figure 3: Waiting times for Inbound patients

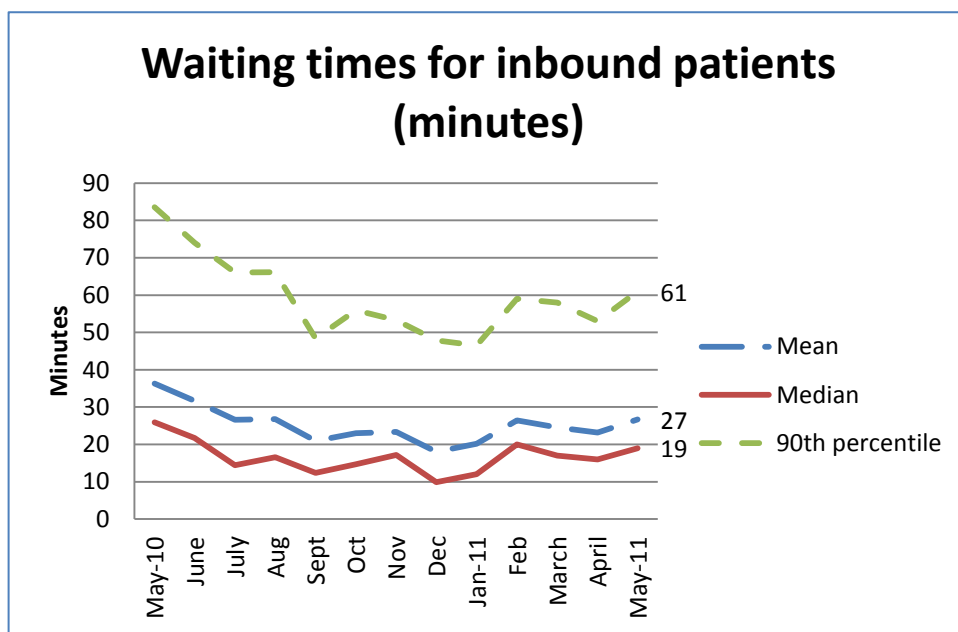
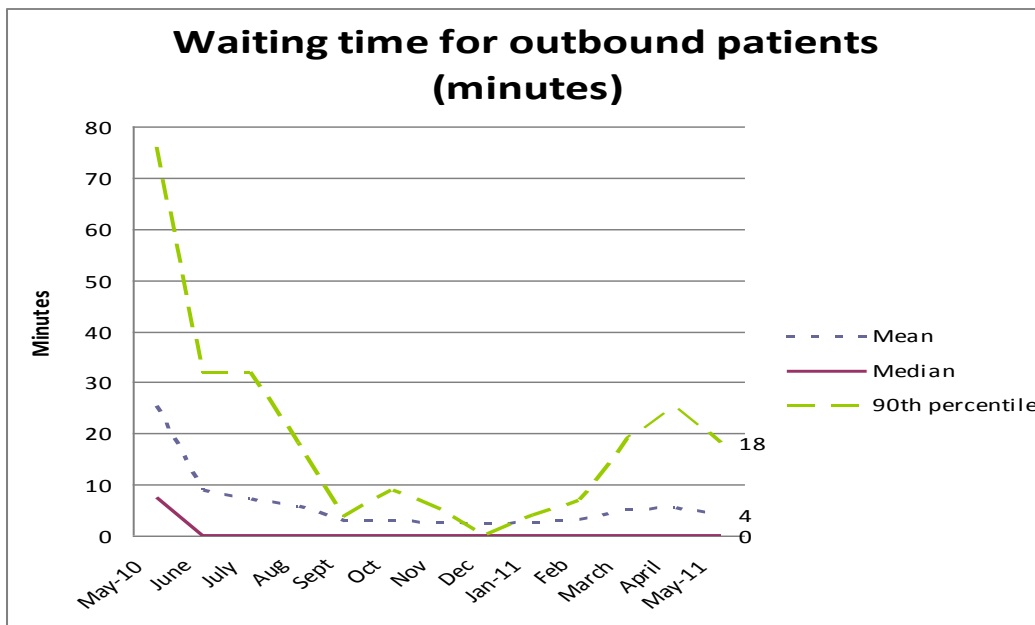


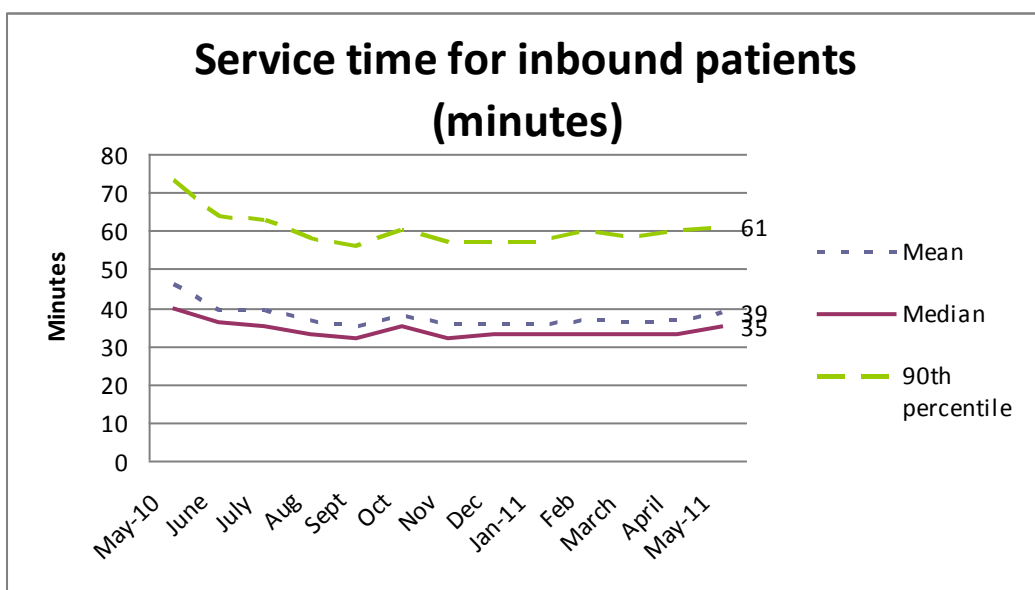
Figure 4: Waiting times for Outbound patients



Waiting times for Outbound patients are expected to be very low, and indeed this is now the case. Clearly in the early months a small number of patients who became Outbound after preliminary assessment waited for some time, and while the median waiting times for Outbound patients are now 0 minutes and the mean only 4 minutes, with the increase in activity in 2011 the reported 90<sup>th</sup> percentile level has grown to around 20 minutes.

It should be noted that the waiting time is calculated from the time a presentation is registered on the computer, to the time the patient file is opened by the nurse. As not all registration is able to be undertaken instantly some patients will be in the Walk-in Centre for a somewhat longer period than the computer reported waiting time before they are seen, and similarly some nurses may open the files to brief themselves before calling for a patient again leading to the time perceived by the patient and the time recorded in the system being inconsistent.

Figure 5: Service times for Inbound patients

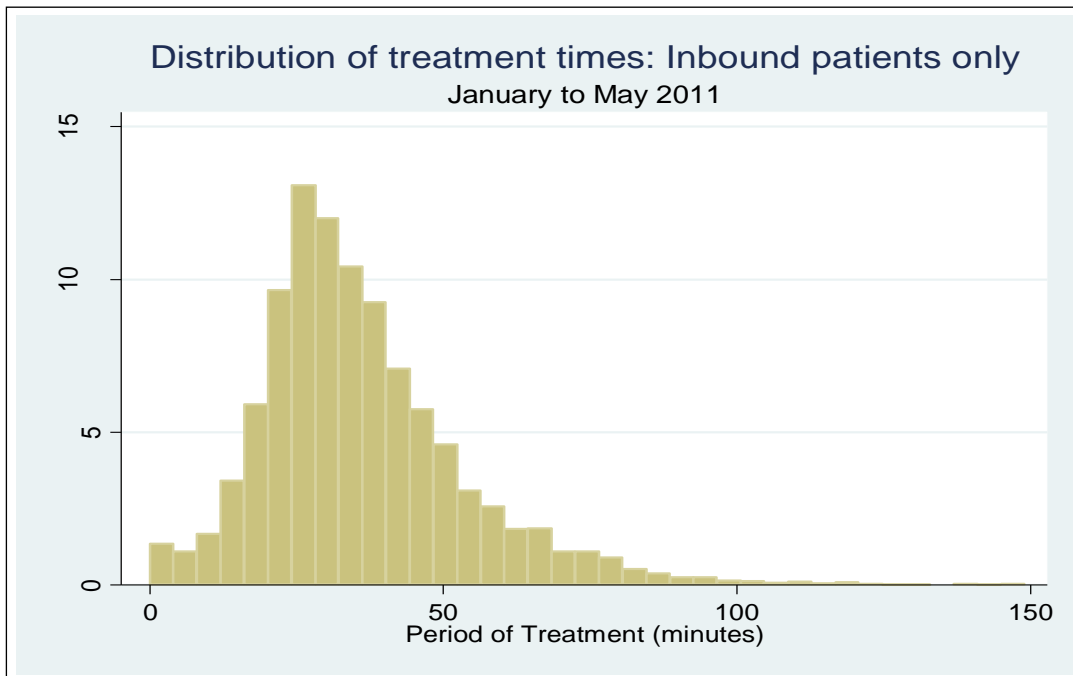


Service times also gradually reduced until late 2010, and have been more or less stable since. The service times were initially longer in part because services include the use of a computer based protocol, and with the passing of time nurses have become more efficient in the use of the protocols. As Outbound patients are not treated, service time is not relevant for them.

*Data note: These numbers are all close to those in the KPI report. Differences may be due to the slightly different definitions of Inbound/Outbound, but more likely because there are some reporting errors in times may have been managed differently. For example in this analysis the extreme cases are omitted (waiting times or treatment times which extended from one day to the next for example have been omitted – omitting very few observations, and having a small effect on medians and percentiles but sometimes major effects on estimated means.*

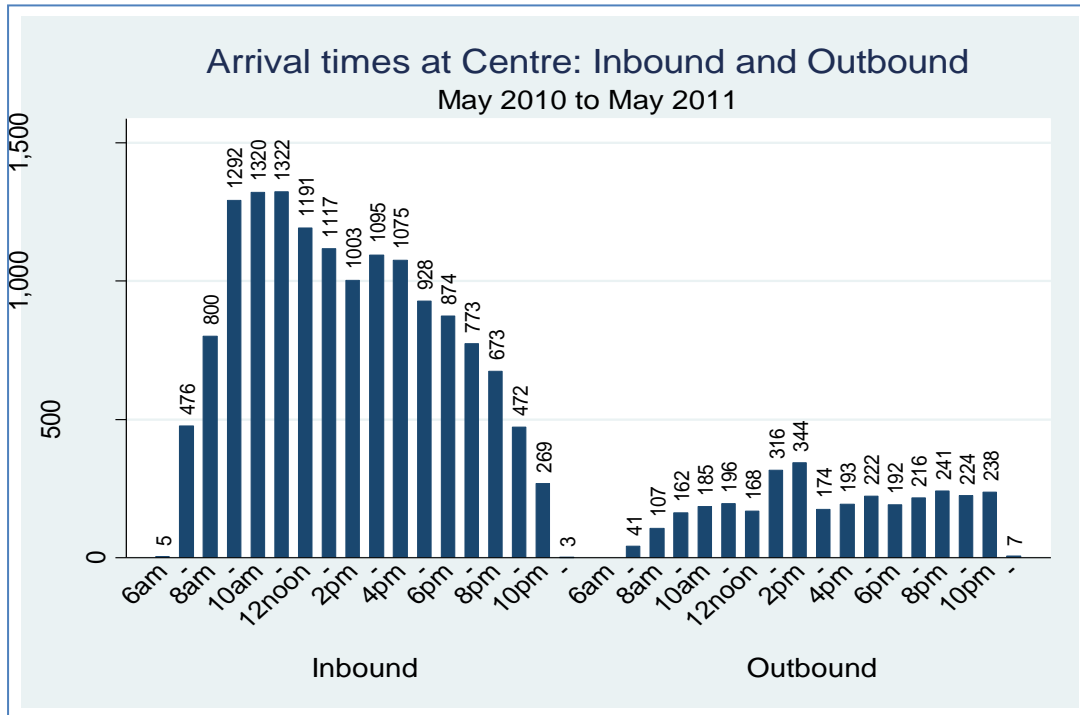
Figure 6 shows the distribution of treatment times is quite broad, with both very short and very long attendances with the nurses and with a peak around 20-30 minutes.

**Figure 6: Treatment times – Inbound patients only**



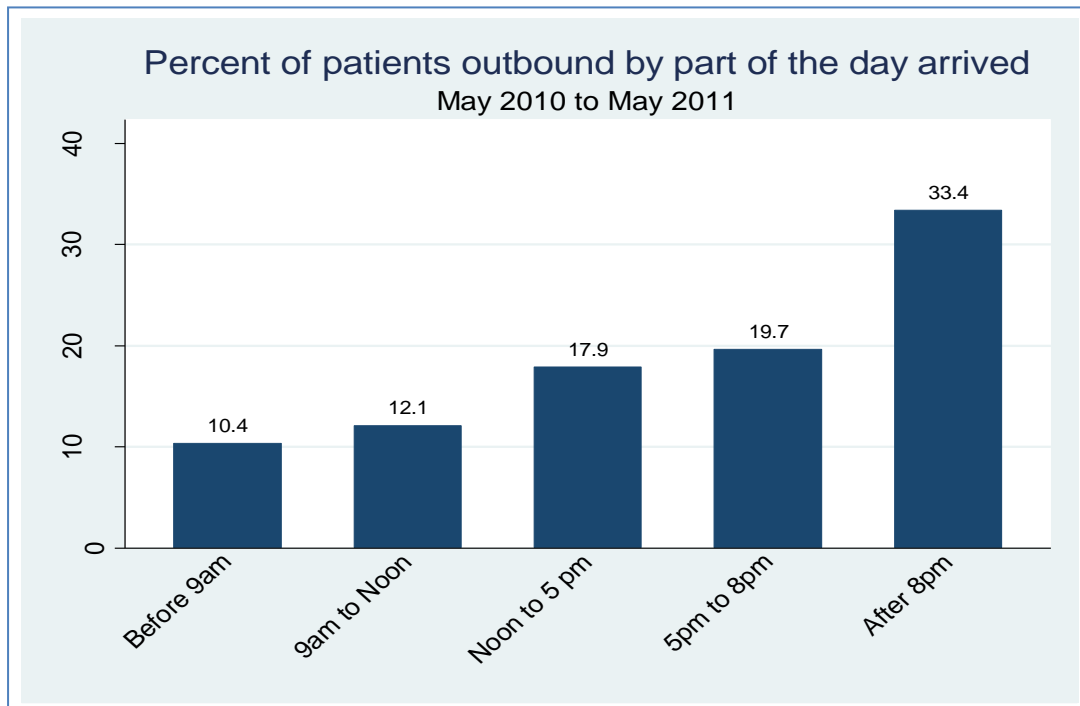
When do patients attend?

Figure 7: Arrival times – Inbound and Outbound patients



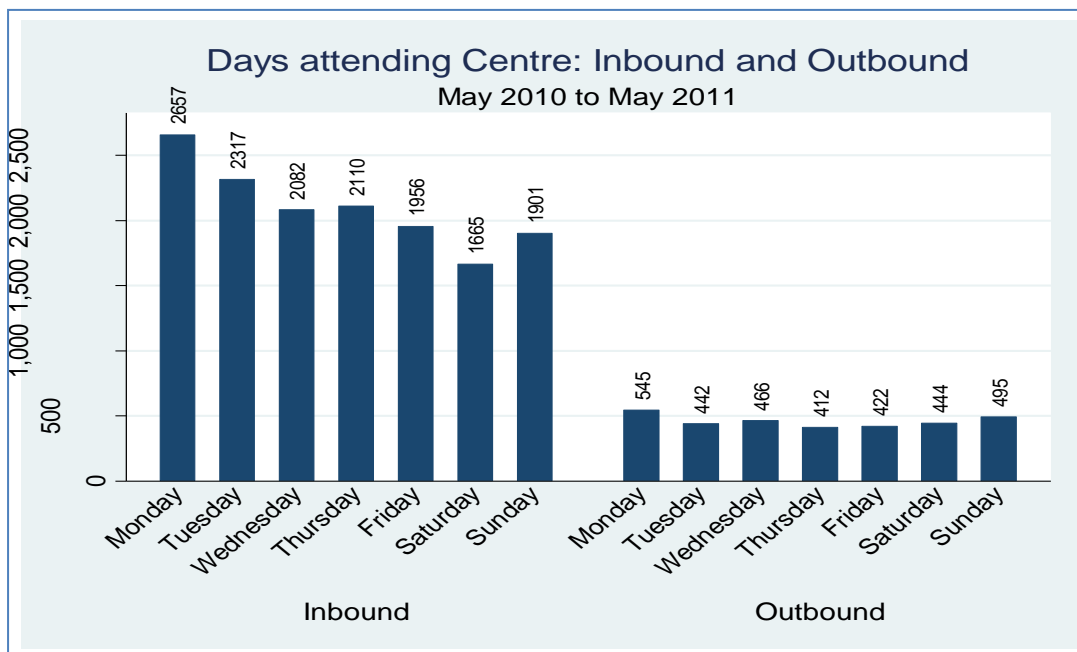
Relatively few patients arrive before 9 am, with a peak 9 – 11 am and numbers then declining through the day with quite small numbers after 10pm. In fact, over the 365 days included in these charts, there were 272 Inbound patients arriving and 245 Outbound patients arriving after 10pm. Across the period of the activity of the Walk-in Centre, the median arrival time for Inbound patients has been 1pm and for Outbound patients 3pm.

Figure 8: Percent of Outbound patients at different times of day



The percentage of patients who are Outbound rises during the day, with the highest percentages in the evening and in particular late in the evening. Discussion with Walk-in Centre staff suggests that patients arriving too late to be seen by the nurses are referred on as appropriate and treated as Outbound. Another component of the higher proportion of Outbound patients after hours is that the Walk-in Centre cannot refer to diagnostic imaging, and suspected fractures need to be referred to the emergency department for scans after 5 pm and so are treated as Outbound.

Figure 9: Days attending – Inbound and Outbound patients



Service numbers decline generally from a highest number on Monday through to a lowest number on Saturday, with Sunday much busier than Saturday on average, but still the second quietest day. While the proportion of Outbound patients is highest on Saturday and lowest on Thursday the differences are not large. One reason for the higher proportion of Outbound patients on Saturday will be that the Walk-in Centre is unable to refer to diagnostic imaging after hours or on weekends, so patients with suspected fractures will be re-directed to the Emergency Department where imaging is available. As noted above this may also be part of the reason for higher levels of Outbound patients late in the evening.

#### How does waiting time and service time relate to hour of day?

Average waiting times, however measured, increase gradually during the day to peak at between 12 noon and 1pm, with secondary peaks at 6 and 8 pm. These patterns are consistent with the patterns of patient arrival at the Walk-in Centre shown in earlier charts, so that as would be expected waiting times are longer at busier times.

Treatment times are much more stable, and means and median are much more similar showing that the distributions of treatment times are less extreme. Treatment times are lower at 2 pm and higher at 3pm which is the time of nurse turnover. They are also lower very late in the evening which may be due to patient selection when there may not be time to accommodate patients.

Figure 10: Waiting time by hour of day – Inbound patients

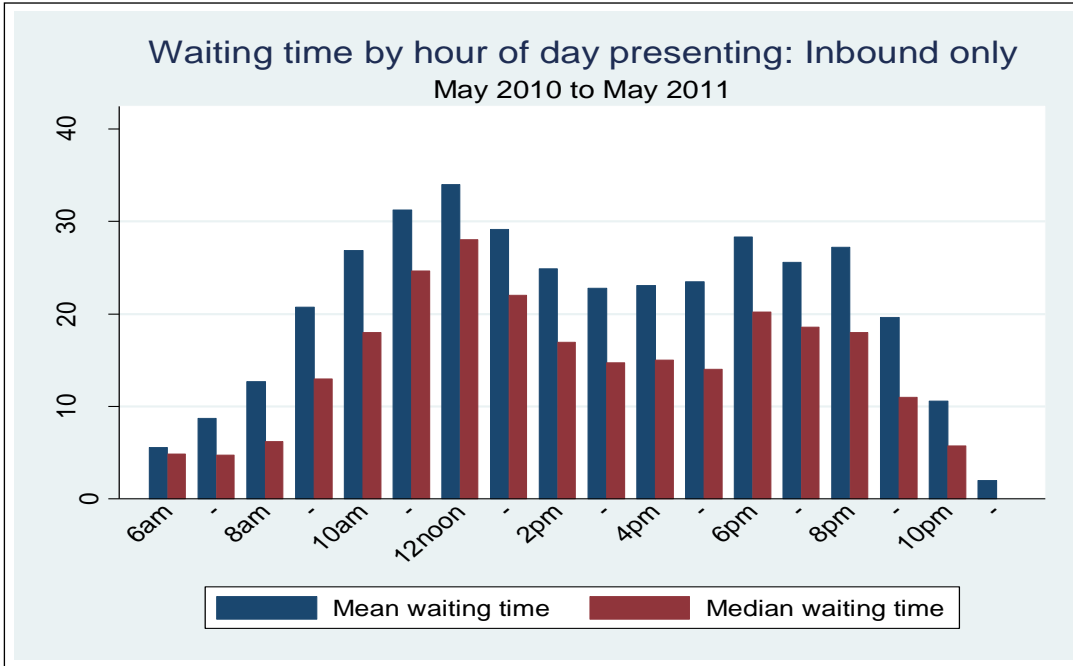
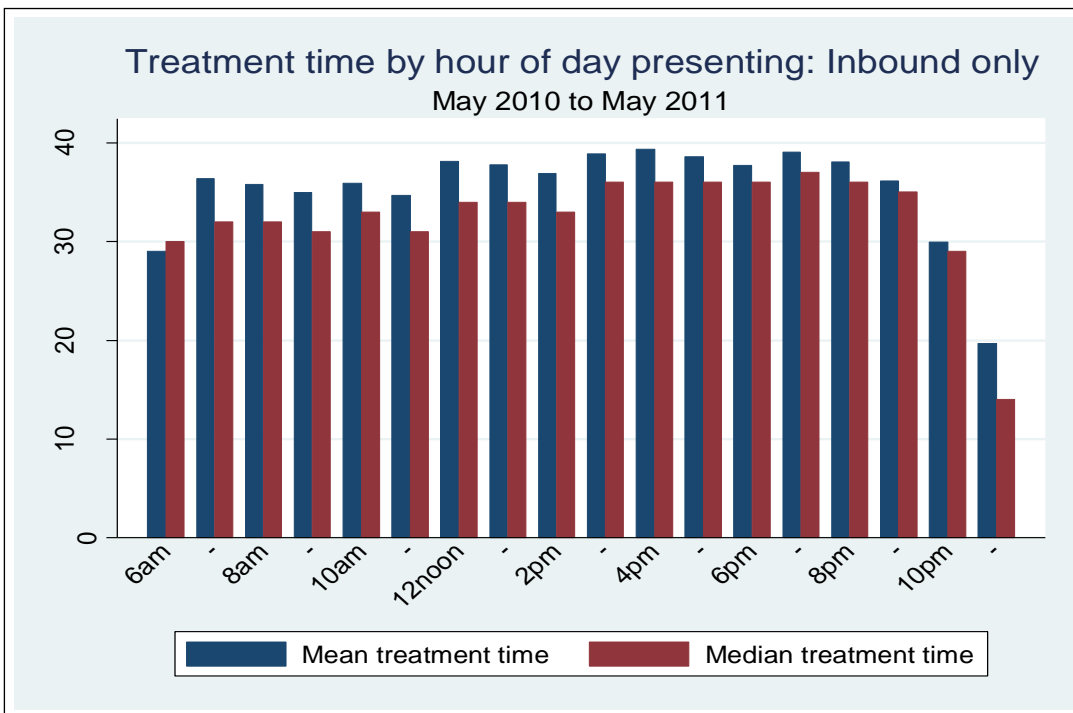


Figure 11: Treatment time by hour of day – Inbound patients



How does waiting time and service time relate to days of the week?

As would be expected waiting time patterns follow quite directly the attendance patterns of patients – waiting times are longer on busier days and shorter on quieter days. Treatment times appear to trend very gently upwards from Monday to Sunday, but the numbers are fundamentally stable.

Figure 12: Waiting time by day presenting – Inbound patients

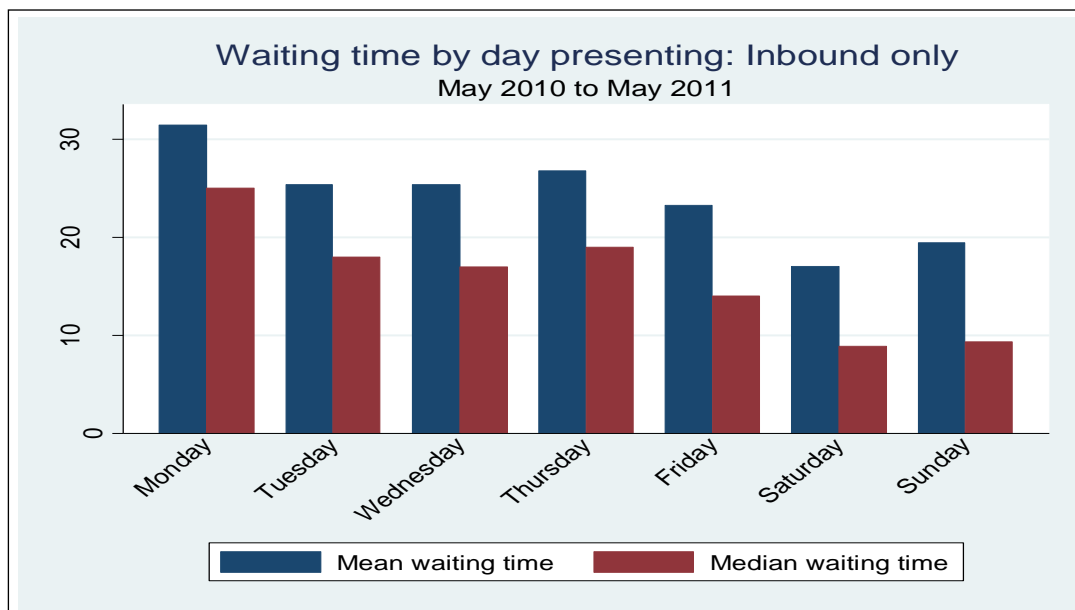
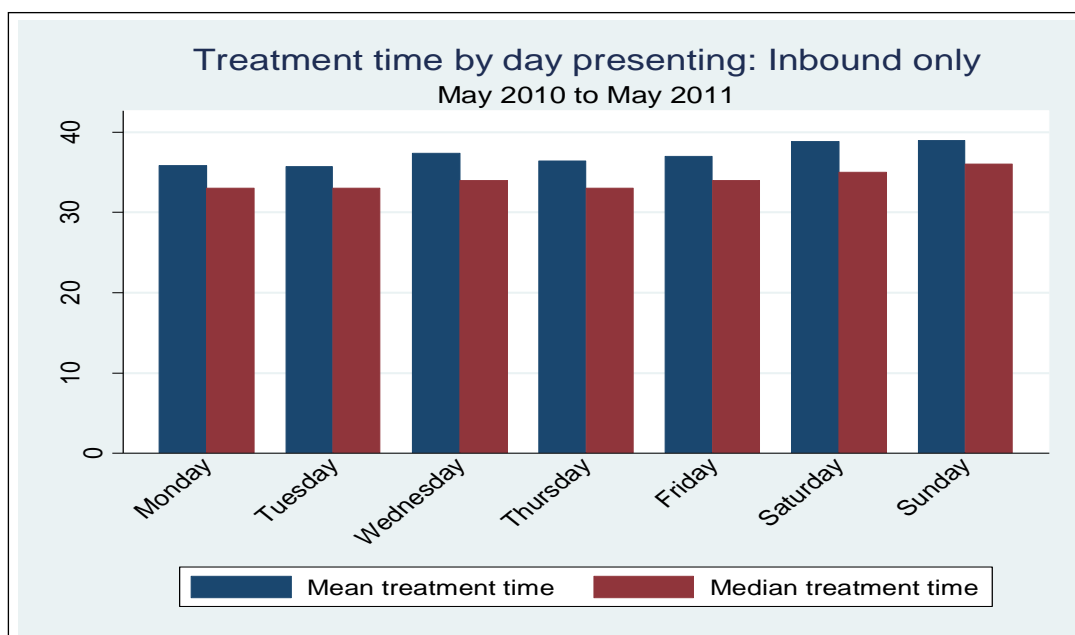


Figure 13: Treatment time by day presenting– Inbound patients



### Who attends the Walk-in Centre – demographics?

The Inbound and Outbound age patterns are similar except that as the very young children are out of scope almost all of those presentations are Outbound. The peak age group is 20 – 29 years, with a mean of 29.6 and median of 27. Overall 54.2% of Inbound patients are female with the percentage female of those treated (the Inbound) increasing with age (as of course does the wider population).



Figure 14: Number of patients by age – Inbound patients

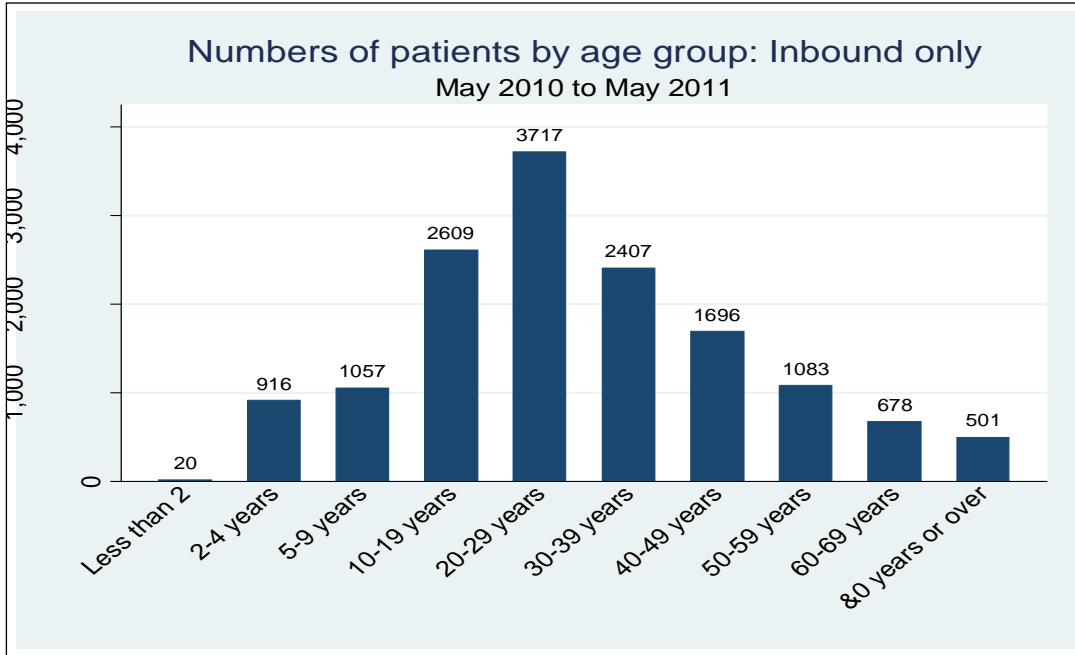
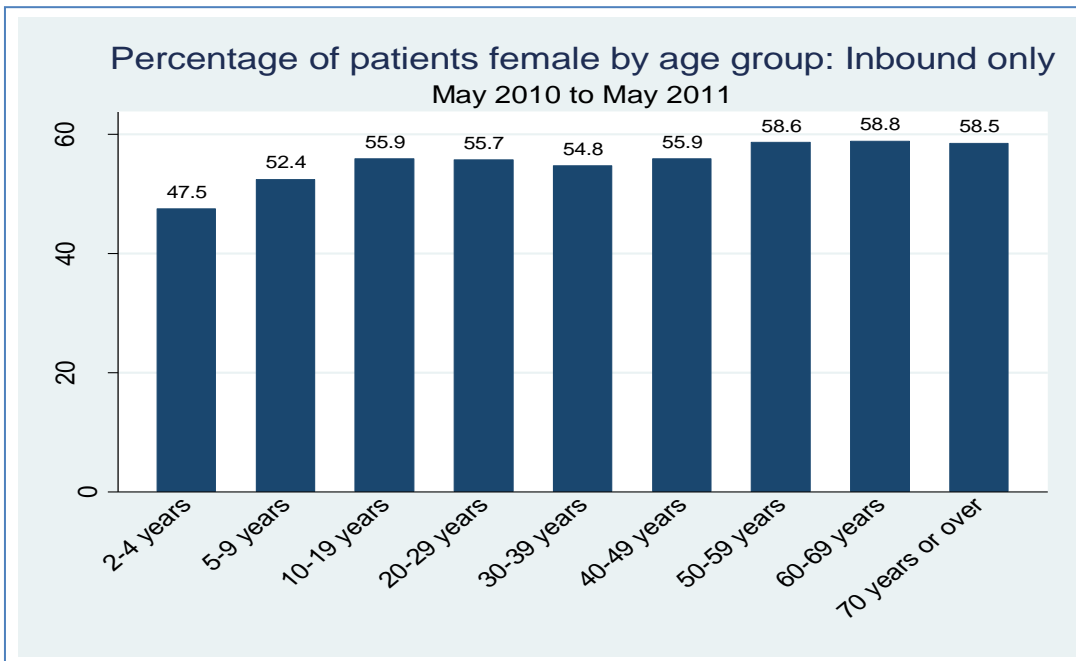


Figure 15: Percent of patients who are female by age – Inbound patients



Data note: while ages for Inbound patients follow a “smooth” pattern, as the ages of Outbound patients are estimated by the receptionists they lump on the 5 years (i.e. year of birth 1960, 1965, 1970 etc).

#### Do different groups of patients attend on different days of week/times of the day?

A priori, one might expect different patterns of attendance for different demographic groups at different times and different days of the week. Perhaps the young may be more likely to attend on weekends, and older people in the middle of the day rather than late at night.

There are minimal effects of time of day or day of week on gender of presentations (the two extreme values at 6am and 11pm are based on 5 and 10 observations respectively).

Figure 16 Figures 16 and 17 show that there is little difference by gender, except that females are less likely to arrive very late in the day, and while there is no day effect on age, the average age of patients declines from around 1pm. This is probably a mixture of less older people attending and more children brought in after school and at night. The following charts relate to Inbound patients only.

Figure 16: Percent of patients who are female day of week attending – Inbound patients

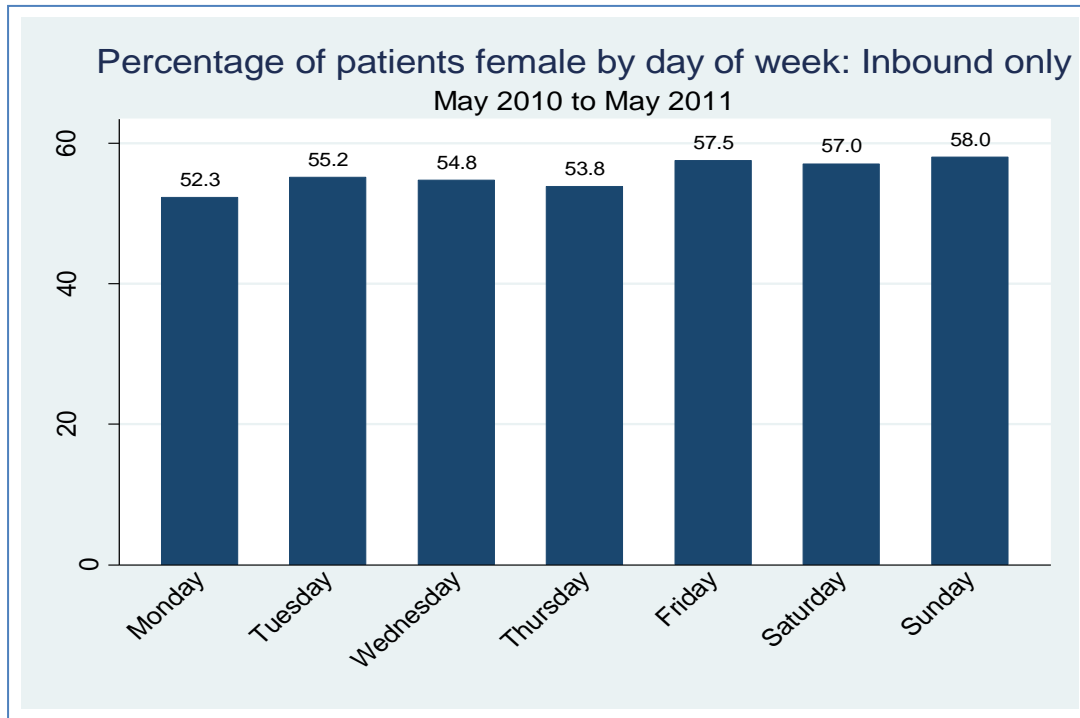


Figure 17: Percent of patients who are female arrival time – Inbound patients

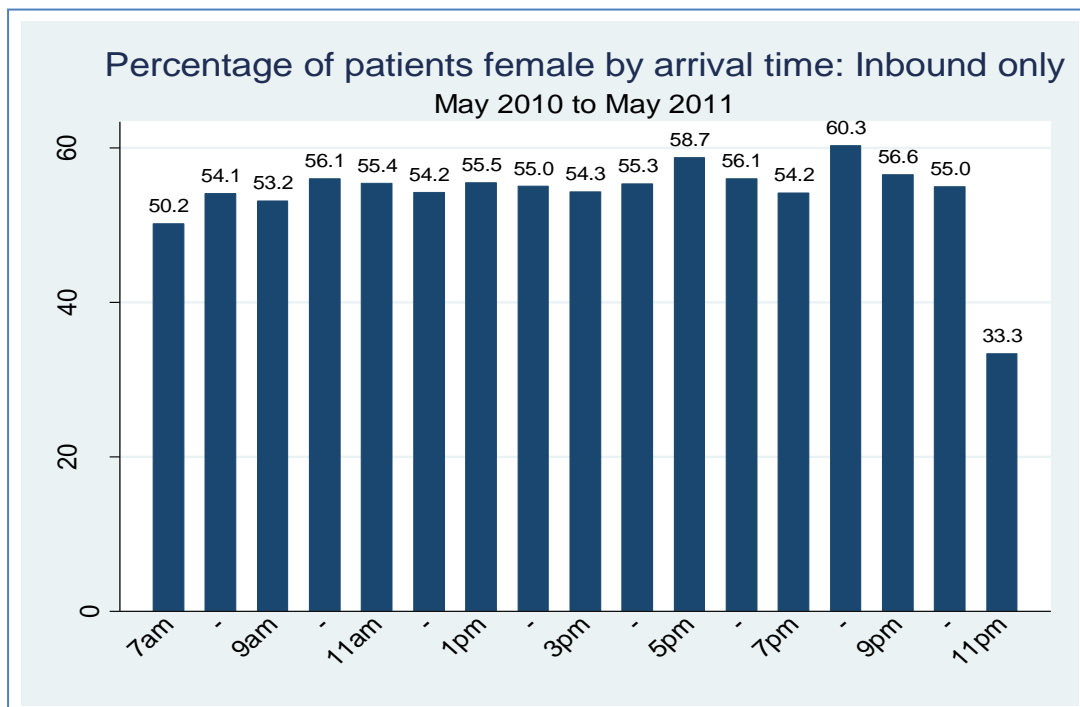


Figure 18: Average (mean) age of patients by day of week attending – Inbound patients

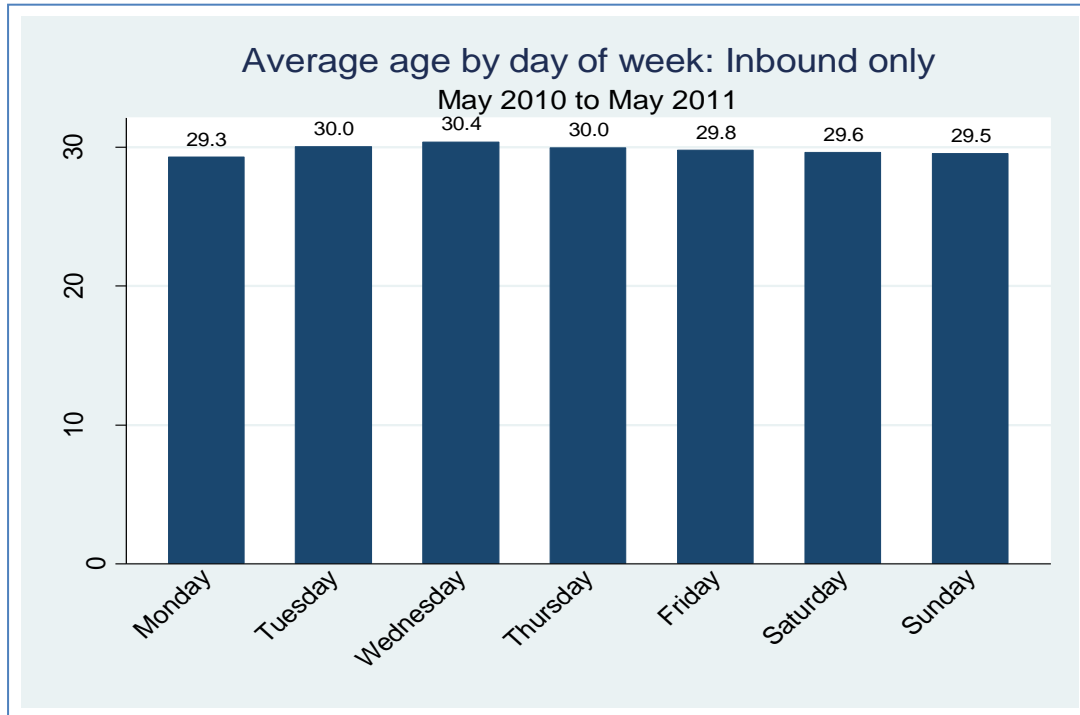
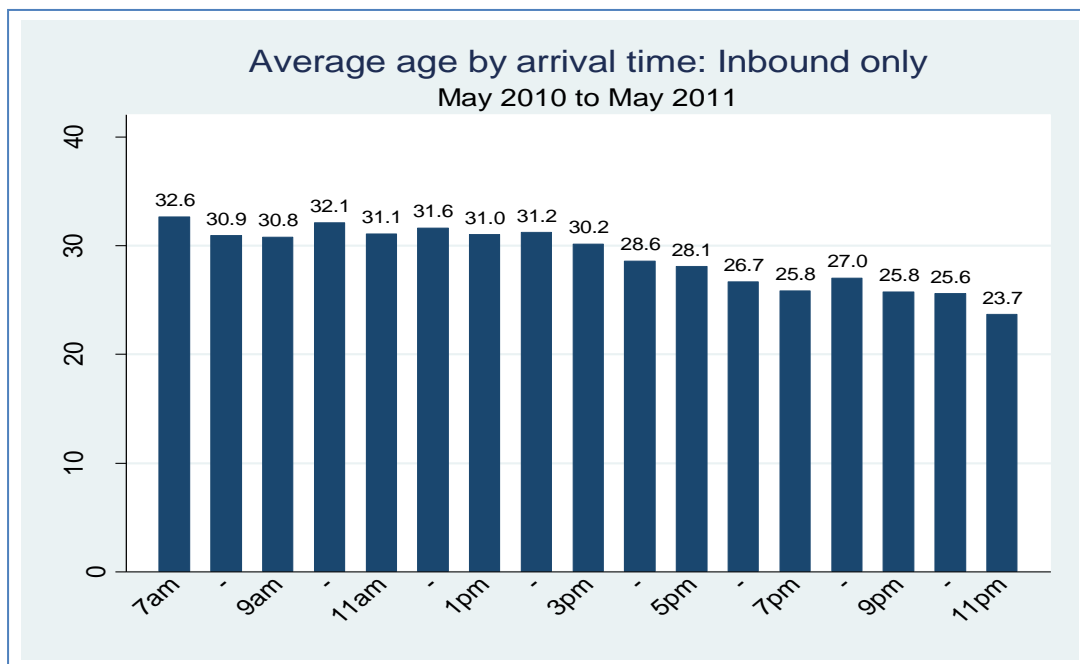


Figure 19: Average (mean) age of patients who by arrival time – Inbound patients



## Where do the patients live?

**Table 1: State of residence of patients: May 2010 to May 2011**

State or Territory	Inbound patients	Outbound patients	Total
ACT	12,975	442	13,417
NSW	1,401	69	1,470
VIC	78	3	81
QLD	55	3	58
SA	24	-	24
WA	27	2	29
TAS	7	-	7
NT	4	-	4
Missing	117	2,707	2,824
<b>Total</b>	<b>14,688</b>	<b>3,226</b>	<b>17,914</b>

The majority of patients come from the ACT and surrounding areas of NSW. While 203 come from other states, 1,060 come from parts of NSW which are in the immediate area of the ACT (see Table 2) and 410 from other areas of NSW.

Some of the areas around the ACT are close enough so that people may have deliberately travelled to the Walk-in Centre, while others are further away (and in some cases well served with local primary care) and are more likely to use the Walk-in Centre because they work nearby. This data set does not allow us to separate the reasons for travel to the Walk-in Centre. Table 2 shows the areas of NSW counted as “immediate area” for the purposes of the previous paragraph.

**Table 2: Location of patients in proximity to Canberra (Inbound and Outbound): May 2010 to May 2011**

Town	Number of Patients	Town	Number of Patients
ARALUEN	5	GUNNING	8
BINALONG	2	JERRABOMBERRA	201
BOOROWA	2	KARABAR	29
BOWNING	6	KOWEN FOREST	3
BRAIDWOOD	8	MICHELAGO	12
BREDBO	4	MURRUMBATEMAN	30
BUNGENDORE	42	OAKS ESTATE	8
BYWONG	12	QUEANBEYAN	498
CAPTAINS FLAT	17	ROYALLA	17
COLLECTOR	5	SUTTON	18
COOMA	14	THARWA	14
FAIRLIGHT	2	WAMBOIN	17
GOOGONG	17	YASS	43
GOULBURN	9		
GUNDAROO	22	<b>TOTAL</b>	<b>1,060</b>

**Table 3: Location of patients by region in Canberra (Inbound and Outbound): May 2010 to May 2011**

<b>Region of Canberra</b>	<b>Number of ACT patients</b>	<b>% of ACT patients</b>	<b>% of population†</b>
Gungahlin-Hall	587	4.4%	11.6%
Belconnen	1,061	7.9%	25.9%
North Canberra	1,221	9.1%	13.3%
South Canberra	1,221	9.1%	7.4%
Weston Creek-Stromlo	1,430	10.7%	6.6%
Woden Valley	2,448	18.3%	9.6%
Tuggeranong	5,304	39.6%	25.5%
ACT - Balance	29	0.2%	0.1%
Missing	88	0.7%	
<b>Total</b>	<b>13,389</b>	<b>100.0%</b>	<b>100.0%</b>

† estimated resident population at 30 June 2009

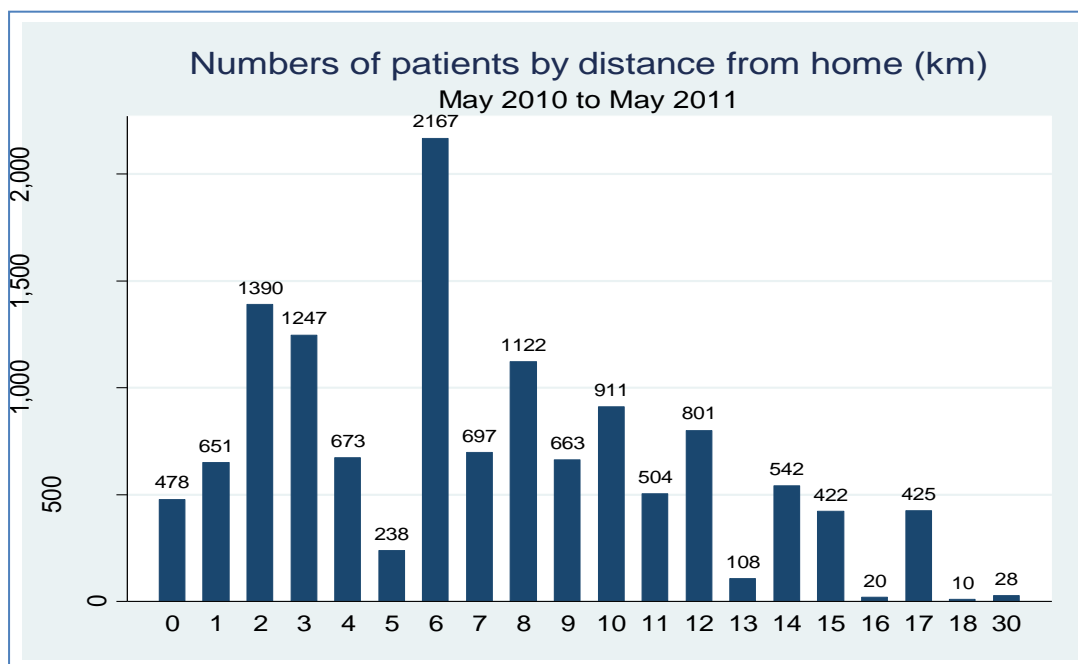
The areas of the ACT closest to the hospital have both the greatest number of patients, and the greatest number relative to population. There are, however, patients from all areas of Canberra. Some of these may live elsewhere and work in Woden, others may travel from other parts of Canberra specifically to receive care at the Walk-in Centre. This information is not available.

Table 3 shows that people from Gungahlin – Hall, Belconnen and North Canberra are less likely to visit the Walk-in Centre than would be expected from their population proportions, while those from Woden Valley, Weston Creek and Tuggeranong are much more likely to visit. This more or less north/south division broadly reflects travel distances.

The distances travelled are analysed below with respect to the ACT only. Clearly some people from parts of NSW also travel to the Walk-in Centre, but for the purposes of this study of travel distances of those people are excluded. There is no formally defined catchment other than the ACT, and it was not clear which NSW areas if any should be included in any study of distance travelled.

The distances travelled to the Walk-in Centre by ACT residents vary widely, with only a few from areas over 20 kilometres from the Walk-in Centre (patients from Uriarra). The data set does not include full addresses but does include suburbs. The distances calculated are distances from the Walk-in Centre to the centroids of the relevant suburbs. This inevitably shows peaks for the larger suburbs (e.g. Kambah). Figure 20 shows peaks at 2 and 6 kilometres because of the clustering of the estimated differences. The six kilometre distance for example includes Acton, Campbell, Canberra City, Chapman, Duffy, Duntroon, Erindale, Fadden, Kambah, Reid and Wanniassa. It must also be noted that these are distances “as the crow flies” and road distances will be different. However, Figure 20 provides an indication of travel distances, with around half of the patients coming from suburbs six kilometres or less from the Walk-in Centre, and around half from suburbs more than six kilometres from the Walk-in Centre.

Figure 20: Distance travelled to the Walk-in Centre– Inbound and Outbound patients



### Socio-economic status of patients

The socio-economic status of the suburbs in which patients live has been identified and compared with that of the overall ACT population<sup>2</sup>. Table 4 shows the classification of the socio-economic measure of disadvantage classified into deciles (defined by ABS) within the ACT. The lowest decile has the greatest socio-economic disadvantage and highest decile the least disadvantage.

The table shows the proportion of the Walk-in Centre population and the overall population in each category, and shows little difference between the patients and population suggesting that all social groups are making use of the service. The relative over-representation of patients in decile 4 is due to Kambah and Wanniasa, two of the largest suburbs in the natural catchment of the Walk-in Centre being in decile 4.

<sup>2</sup> Taken from ABS data cube at <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/2033.0.55.0012006?OpenDocument>

**Table 4: Socio-economic status of patients compared to overall ACT population (Inbound and Outbound): May 2010 to May 2011**

<b>SEIFA Decile</b>	<b>Patients</b>	<b>Percent of Patients</b>	<b>Percent of ACT population<sup>3</sup></b>
1	663	5.0%	6.4%
2	1,154	8.7%	9.9%
3	1,303	9.9%	8.8%
4	2,617	19.8%	14.7%
5	1,413	10.7%	12.1%
6	1,734	13.1%	15.0%
7	1,473	11.2%	10.9%
8	743	5.6%	5.7%
9	1,261	9.6%	8.5%
10	847	6.4%	8.0%
<b>Total</b>	<b>13,208</b>	<b>100.0%</b>	<b>100.0%</b>

*Data note: the SEIFA scores are taken from 2006, so areas such as those in north Gungahlin which were developed more recently are not covered. There are however relatively few patients from these areas (a total of around 90).*

#### How many patients are treated/referred etc?

Most Outbound patients by definition are not treated and are referred to other providers. Inbound patients on the other hand are mostly treated (unless examination identifies some problem outside of scope or they do not wait for treatment). However, while in some cases the condition requires only the treatment provided by the nurse, in others it is necessary to suggest that the problem be followed up by the patient with a doctor or with ED or with some other provider. The table below shows both the nature of these referrals following treatment, and the numbers who are not treated for particular reasons.

The need for further referral arises for many reasons but discussion with the staff and observation suggests that the main reasons are:

- > Referral for an ongoing problem, including the need for further wound management;
- > Referral for prescription of a medication outside the Walk-in Centre formulary (most often an antibiotic);
- > Referral for a condition which on further inspection is outside the Walk-in Centre protocol;
- > Referral to ED for an X-ray or scan out of hours, as direct referral to hospital imaging services is only available within standard hours.

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<sup>3</sup> Note that the decile is defined by numbers of suburbs so there is the same number of suburbs in each decile which does not give the same numbers of people each decile.

**Table 5: Final treatment status of patients (Note that all Inbound patients are treated and redirection follows treatment): May 2010 to May 2011**

Final treatment status	Inbound	Outbound	Total
	Numbers of patients		
<b>Treated/Advised</b>			
Treatment provided in Walk-in Centre	8,463	16 <sup>£</sup>	8,479
Treatment & Health Information provided in Walk-in Centre	777	1	778
Health information provided in Walk-in Centre	88		88
Redirection to CALMS	231	255	486
Redirection to ED - TCH and others	786	1,320	2,106
Redirection to GP	3,038	1,276	4,314
Redirection to Medical Imaging	607	2	609
Redirection to Pharmacy	69	9	78
Redirection to Registrar Review/Outpatients	242	4	246
Redirection via CATT Team	32	3	35
Redirection to Antenatal Services	4	2	6
<i>Total Treated</i>	<i>14,337</i>	<i>2,888</i>	<i>17,225</i>
<b>Not Treated or Unknown</b>			
Patient left Walk-in Centre before assessment	111	186	297
Patient left Walk-in Centre during Treatment	12	1	13
Code Blue Activated	8	6	14
Intervention by Security/Police	1		
Not within Scope	5	14	19
Walk-in Centre Shutdown - redirected to ED	13	4	17
Walk-in Centre Shutdown - redirected to GP	5	10	15
Missing	196	117	313
<i>Total not treated or unknown</i>	<i>351</i>	<i>338</i>	<i>689</i>
<b>Total</b>	<b>14,688</b>	<b>3,226</b>	<b>17,914</b>

<sup>£</sup> coded to Outbound because no nurse allocated in database. All but one case treated in rooms.

This shows that 63% of Inbound patients are treated in the Walk-in Centre (with or without provision of written information) with no need for further treatment.<sup>4</sup> Following treatment in the Walk-in Centre 21% are redirected to GPs for further treatment and 5% redirected to ED (almost all at TCH) for further treatment. 2.4% of Inbound patients are not treated or have missing codes. 89.5% of Outbound patients are redirected to appropriate alternate providers. Only 1.7% of all patients leave before or during treatment.

A brief examination of the final treatment status according to day of the week shows little effect for different weekdays, but a larger effect for weekends. This is to be expected as on weekends there is no direct access to medical imaging so more patients are sent to the ED for imaging, and many GP practices are closed so there will be less referral to GPs. These are the major differences, together with a higher referral to CALMS (consistent with GP

<sup>4</sup> This is one point at which the percentages from the APHCRI data extract differ from the KPI reports, with the KPI showing 68% treated in the Walk-in Centre. The reason for this difference is not known.



practices being closed). Interestingly, while differences are not large, patients are less likely to leave before treatment on weekends, presumably as they are under less time pressure.

Examination of the final treatment status by time of day (see table at Appendix A) shows the same effects in the sense that referral to medical imaging is reduced after hours and referral through ED increased. Referral to CALMS is minimal before evening as they are not open, but increases with a corresponding decline in GP referrals in the evening and night. The treatment patterns across days and times therefore appear to be very similar apart from the changes driven by structural factors like access to imaging and to CALMS.

### What conditions are treated?

Data on conditions treated is complex to deal with as it is provided at a fine level of detail with no structured means of aggregation. The Walk-in Centre KPI reports for example, show the top 10 types of conditions treated by nurses as Upper Respiratory Tract Infection (URTI) (separate numbers for common cold, tonsillitis, sore throat, sinusitis), wounds and lacerations (separate numbers for lacerations and abrasions), ear conditions/ear wax, ear conditions otitis media, gastroenteritis/diarrhoea and "other".

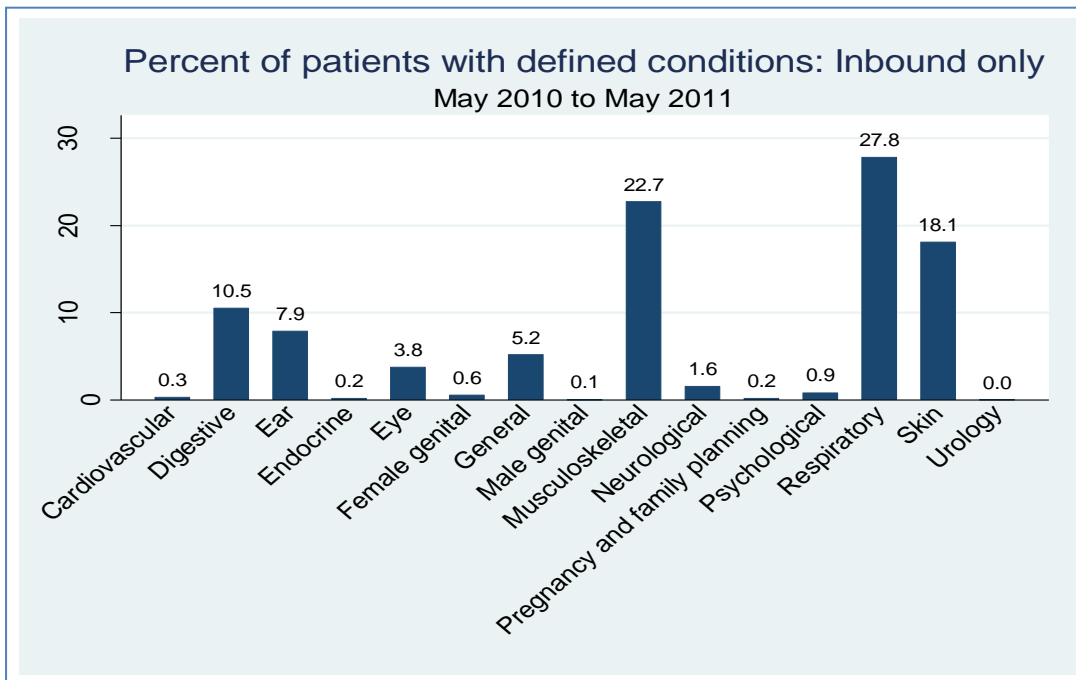
As an alternate means of summarising we have used the classification of the BEACH studies of general practice and classified each reported condition into that set of 17 categories<sup>5</sup>. This means all the URTI conditions are classified as respiratory, and the wounds and abrasions largely as skin problems. Many of the BEACH categories (such as blood conditions) are not relevant to the Walk-in Centre or have very small numbers. Some of the categories were also difficult to locate in the BEACH structure so broad clinical judgement was applied. The areas with potential errors however are relatively small and do not impact on the overall picture. The chart below shows the percentage of patients in each of these broad categories.

The main categories are respiratory with URTI conditions referred to above, musculoskeletal which are predominantly potential fractures of various parts of the body, skin which includes lacerations and abrasions but also a range of rashes, ear which includes ear wax and otitis media, digestive which is a range of conditions frequently evidenced by vomiting and diarrhoea, and eye conditions for which there is a wide range, with infections the most common.

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<sup>5</sup> See for example Britt H, Miller GC, Charles J, Henderson J, Bayram C, Pan Y, Valenti L, Harrison C, O'Halloran J, Fahridin S 2010. General practice activity in Australia 2009-10. General practice series no. 27. Cat. no. GEP 27. Canberra: AIHW.

Figure 21: Major clinical problem categories: Inbound patients



Examination of the conditions arising on weekdays in comparison to weekends shows little difference, although there are relatively more ear problems and skin problems on the weekends and more musculoskeletal problems on weekdays. Similarly patterns are relatively stable across the day, although there are relatively more skin conditions in the evening, and relatively less musculoskeletal and respiratory conditions.

Apart from obvious conditions which are gender related (e.g. pregnancy related matters) the main differences in presenting conditions for men and women were a somewhat lower female representation for eye problems and musculoskeletal problems, and a somewhat higher female representation for digestive, psychological and respiratory problems. There are few condition groups with significantly older or younger patient groups, although cardiovascular conditions and psychological conditions comprise patients who are older on average. Waiting times do vary across conditions but this is probably related to time of presentation rather than the condition as patients are taken in order of presentation. Treatment times are relatively stable across conditions although psychological problems have somewhat longer treatment times and respiratory conditions somewhat shorter treatment times than the average.

#### How do patients find out about the Walk-in Centre?

There are a wide range of sources of information about the Walk-in Centre from the backs of buses to television advertising to other clinicians. Table 6 shows that family and friends are the major source of information (predominantly for the Outbound patients), that there are significant numbers of repeat attendees, and that television advertising leads to a number of people attending the Walk-in Centre.

Table 6: Source of referral to the Walk-in Centre: May 2010 to May 2011

Source of Referral to the Walk-in Centre	Inbound patients	Outbound patients
ED referral	3.0%	2.0%
Friend / Family	31.8%	46.8%
GP	2.3%	2.9%
Print Media	7.6%	1.2%
Radio	5.8%	0.4%
Self Referral	6.1%	31.5%
TCH staff self referral	3.9%	0.5%
Television	9.6%	1.4%
Website	2.4%	0.7%
Walk-in Centre	3.7%	1.4%
Other	6.6%	11.0%
Repeat Attendee	17.1%	0.2%
<b>Total responding</b>	<b>100.0%</b>	<b>100.0%</b>
<i>Note that small categories aggregated into "Other"</i>		



## Chapter 3 Walk-in Centre patient satisfaction survey

### BACKGROUND

In order to determine the success of the ACT Health Walk-in Centre, the views of the individuals who have used the centre is of utmost importance. A survey was conducted with the users of the Walk-in Centre to ascertain their access to and satisfaction with the ACT Health Walk-in Centre. This survey complements the audit of the CDSS data conducted to examine the demographic characteristics of the Walk-in Centre population, describe the attendance patterns at the Walk-in Centre and examine the outcomes of patients' visits.

This survey fits within the framework for the evaluation of the ACT Health Walk-in Centre which was adapted from the 'Conceptual framework for performance assessment in primary health care'<sup>22</sup>. It comprises a quality aspect of the framework that examines the efficiency of the Walk-in Centre with regard to the intermediate outcomes for patients, which includes access and satisfaction.

### METHODS

Ethics approval to conduct a survey examining patient satisfaction in the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.11.033) on the 8<sup>th</sup> March 2011 and subsequently given expedited approval by The Australian National University Human Research Ethics Committee on the 16<sup>th</sup> March 2011 (protocol no. 2011/121).

#### Development of survey

The initial draft of the survey was based on the patient satisfaction survey used by the NHS Walk-in Centre evaluation team in the United Kingdom<sup>3</sup>. The chief investigator, Prof Chris Salisbury, from the NHS Walk-in Centre evaluation team gave permission for the APHCRI team to use this survey and modify it to the ACT context, provided there was due acknowledgement in any publications.

The NHS Walk-in Centre patient satisfaction survey was adapted to the ACT context in the following ways:

- > Demographic questions were included to appropriately reflect Australia's multicultural population comprised of Indigenous peoples and immigrants. Therefore, questions were included about Aboriginal and Torres Strait Islander status, international region of birth and first language. Furthermore, questions were included about employment status, living arrangements, income, private health insurance, and possession of Australian-specific health care cards.
- > The section on access to the Walk-in Centre was modified to include questions about how patients had travelled to the Walk-in Centre as there were significant parking issues at the Walk-in Centre site and it was anticipated that these may hinder patient satisfaction. The question about patients' reasons for attending the Walk-in Centre was modified to the ACT context.
- > The section on patients' satisfaction was adapted to exclude questions about which health professional provided the consultation, as unlike some of the UK Walk-in Centres, the ACT Health Walk-in Centre is only staffed by nurses. Additionally, the question about the length of time patients waited for a consultation was removed as the APHCRI research team perceived the answers to the question may be subjective and these data were collected through the CDSS audit.

## Format of survey

The patient satisfaction survey consisted of two sections. Part 1 comprised questions about demographics and access to the Walk-in Centre. This section was intended for patients to complete prior to their consultation with a nurse, if there was sufficient time while they were waiting. Part 2 was for completion after the consultation as this section consisted of questions about the patients' satisfaction with the service.

Two versions of the survey were produced: 1) Parts 1 and 2 as one booklet; and 2) Parts 1 and 2 separated into two booklets. This latter version would allow those participants who were able to complete Part 1 prior to their consultation to give it back to the research team before seeing the nurse. These different versions of the survey were piloted to determine the final format.

## Sample size

It was estimated that a sample size of  $n=200$  was appropriate to the study. This sample size was both practical to collect and was large enough to confidently identify differences which were meaningful in substantive terms. With a statistical power of 80%, differences of 20% between groups (for example, a difference of 90% to 70% very satisfied between males and females, between old and young, between morning and afternoon patients) could be identified.

## Survey piloting

The survey was piloted at the Walk-in Centre prior to beginning data collection to determine the approximate response rate, to ensure the clarity of the questions, and to determine which format of the survey should be used.

The patient satisfaction survey was piloted over a period of two days (16 – 17 March, 2011). Thirty patients attending the Walk-in Centre were approached and offered the opportunity to complete a survey. Twenty six (87%) consented to participate. Fifteen returned completed surveys (58% response rate). Of these, eleven completed the survey in the waiting room and returned it to the researcher; four completed the survey at home and returned it by post within three days.

Based on the response rate of 58% received in the pilot, it was determined that the APHCRI research team would need two weeks to distribute 400 surveys to receive 200 completed surveys, according to the average number of daily visitors to the Walk-in Centre.

It was determined that the final format of the survey should be in two parts for ease of distribution for the research team. A number of questions were modified after participants sought clarification.

## Recruitment of participants

The patient satisfaction survey was conducted from the 2<sup>nd</sup> to the 15<sup>th</sup> April 2011. Potential participants were approached in the Walk-in Centre waiting area after they had been registered by the reception staff to see a nurse at the Walk-in Centre. Patients who were triaged by the reception or nursing staff to be outside the scope of the Walk-in Centre and redirected to another health service, were not asked to participate.

The recruiting researchers maintained a running sheet of individuals who accepted or declined to participate. Participants who agreed to participate were given an individually numbered survey and asked to complete Part 1 prior to their consultation and return it to the researcher, if they had enough time. A reply paid envelope was included with the survey and participants were asked to either complete Part 2 immediately after their consultation and give it back to the researcher, or take their survey home to complete and return by post.

## Data analysis

Data were manually entered into an electronic database and analysed using SPSS (IBM SPSS Statistics 19). Numbers and percentages were used to summarise all questions in the survey. To test whether there were any relationships between satisfaction and patient characteristics, logistic regression equations were estimated which attempted to predict which patients were likely to report being highly satisfied for each of the satisfaction questions. An odds ratio (OR) was taken from the logistic regression; only significant results are reported in the findings of this Chapter. The full logistic regression has not been reported, but is available upon request. The patient characteristics tested were:

- > Gender;
- > Age (continuous);
- > Aboriginal or Torres Strait Islander;
- > Country of birth;
- > Language spoke at home;
- > Marital status;
- > Education;
- > Employment status;
- > Living arrangements;
- > Private health insurance held;
- > Health care concession cards held;
- > Income.

## RESULTS

307 patients were approached in the Walk-in Centre waiting room and 277 (90.2%) agreed to participate. Of these, 246 (88.8%) returned completed surveys, where 207 were returned in person and 39 returned using the reply paid envelope.

The sample population was representative of the whole Walk-in Centre patient population for age and gender, as determined by the audit of the Walk-in Centre data (Chapter 2).

### Demographics

73% of the respondents were patients attending the Walk-in Centre, 22% were parents of children attending the Walk-in Centre, and a further 5% were partners, children, other relatives or friends of the patient. There was a fairly equal distribution of males and females, and the age of the patients ranged from <2 – 70+ years; despite children less than 2 years of age being out of the scope of practice of the Walk-in Centre (Table 7).

### Access

30% of the respondents had used the Walk-in Centre previously. The majority, 94%, travelled to the Walk-in Centre by car, in their own car or in a family or friend's car. Likewise, the majority, 92%, found it very (56%) or fairly easy (36%) to travel to the Walk-in Centre.

Respondents perceived the Walk-in Centre's location and opening hours to be convenient (Figures 22 and 23).

**Table 7: Demographics of the survey respondents (n=246)**

<b>Characteristics</b>	<b>n (%)</b>	<b>Characteristics</b>	<b>n (%)</b>
Age in yrs (n=245)		Education (n=245)	
<9	30 (13)	Pre-Primary/Primary	42 (17)
10 – 19	50 (21)	Secondary	54 (22)
20 – 29	62 (26)	Vocational Training	75 (31)
30 – 39	35 (14)	Tertiary	73 (30)
40 – 49	36 (15)	Other	2 (1)
50 – 59	13 (5)	Employment status (n=245)	
60 – 69	9 (3)	Full time work	104 (43)
70+	8 (3)	Part time work	17 (7)
Gender (n=245)		Casual work	13 (5)
Male	111 (45)	Not employed	17 (7)
Female	134 (55)	Retired	14 (6)
Other	1 (<1)	Student	71 (29)
State or Territory (n=233)		Home duties	3 (1)
ACT	216 (92)	Other	5 (2)
NSW	13 (6)	Living arrangements (n=245)	
VIC	3 (1)	Own home or buying home with mortgage	80 (33)
WA	1 (<1)	Private rental	61 (25)
TAS	1 (<1)	Public housing rental	13 (5)
Aboriginal or Torres Strait Islander (n=239)		At home with parents	90 (37)
Aboriginal	8 (3)	Other	2 (1)
Torres Strait Islander	2 (1)	Private health insurance (n=243)	
Country of birth (n=245)		Yes	119 (49)
Australia	201 (82)	Possession of concession cards (n=241)	
New Zealand	4 (2)	Health care card	45 (19)
UK	4 (2)	DVA Gold Card	2 (1)
Europe	10 (4)	Pensioner concession card	13 (5)
America	4 (2)	Commonwealth Seniors health card	2 (1)
Asia	16 (7)	None	180 (74)
Other	7 (3)	Income (n=239)	
Marital status (n=245)		Under \$10,000	9 (4)
Single	138 (56)	\$10,000-\$24,999	14 (6)
Married	64 (26)	\$25,000-\$49,999	30 (13)
Partnered of De Facto	30 (12)	\$50,000-\$74,999	52 (22)
Separated or Divorced	9 (4)	\$75,000-\$99,999	44 (18)
Widowed	2 (1)	\$100,000-124,999	21 (9)
Other	3 (1)	\$125,000-\$149,999	17 (7)
		Over \$150,000	30 (13)
		Don't know	23 (10)



Figure 22: Respondents' rating of the convenience of the Walk-in Centre's location (n=245)

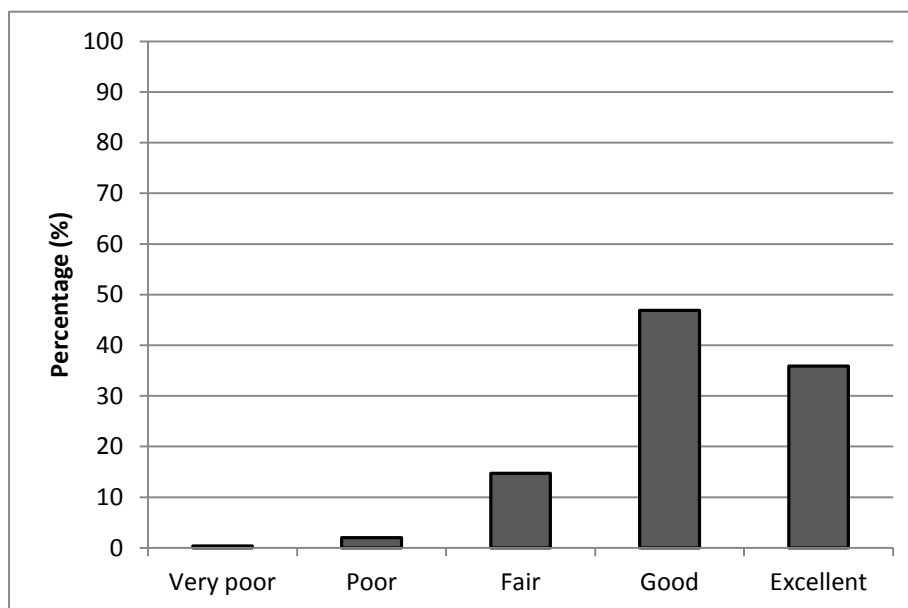
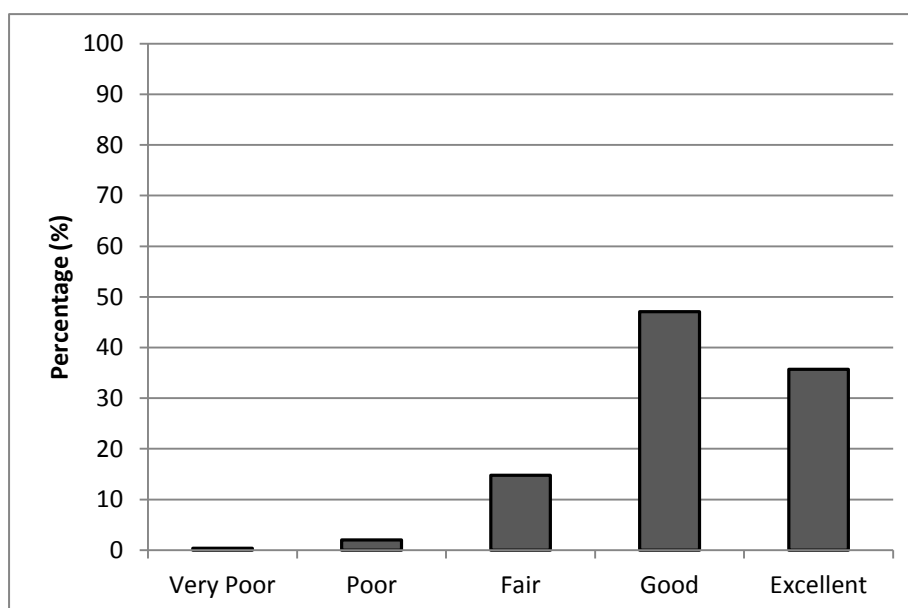


Figure 23: Respondents' rating of the convenience of the Walk-in Centre's opening hours (n=231)



The main reasons<sup>6</sup> respondents came to the Walk-in Centre rather than going elsewhere was because it was quicker than getting an appointment with their GP (59%) and/or they perceived they would encounter a shorter wait than going to the Emergency Department (39%). Other reasons included:

- > 39% Convenient opening hours;
- > 32% Cheaper than getting an appointment at the GP;
- > 31% Convenient location;
- > 22% Quicker than getting an appointment at CALMS;
- > 18% Cheaper than getting an appointment at CALMS;

<sup>6</sup> Respondents could choose more than one reason

- > 10% I don't have a GP;
- > 9% Wanted to see a nurse rather than a doctor;
- > 9% Didn't think about going anywhere else;
- > 8% Sent here by the Emergency Department, GP or Canberra Direct (the health hotline);
- > 6% Had more confidence in the advice/treatment I would get;
- > 5% Didn't want to bother my GP.

If the Walk-in Centre had not been available, 43% of respondents said they would have gone to see a GP and a further 24% would have gone to the Emergency Department. Other respondents said they would have:

- > 10% Gone to CALMS;
- > 5% Gone to see a pharmacist;
- > 1% Called my GP out;
- > 0% Gone to see a dentist;
- > 0% Telephoned health direct (the health hotline);
- > 4% Other:
  - o Come back when it [the Walk-in Centre] was open (n=1);
  - o Gone to Phillip medical centre (n=3);
  - o Stayed at Emergency (n=1);
  - o Stayed at home with parents/family (n=1);
  - o Tried calling another GP (n=1);
  - o Waited, if no improvement booked for GP (n=1);
  - o Waited until Monday for GP (n=1).

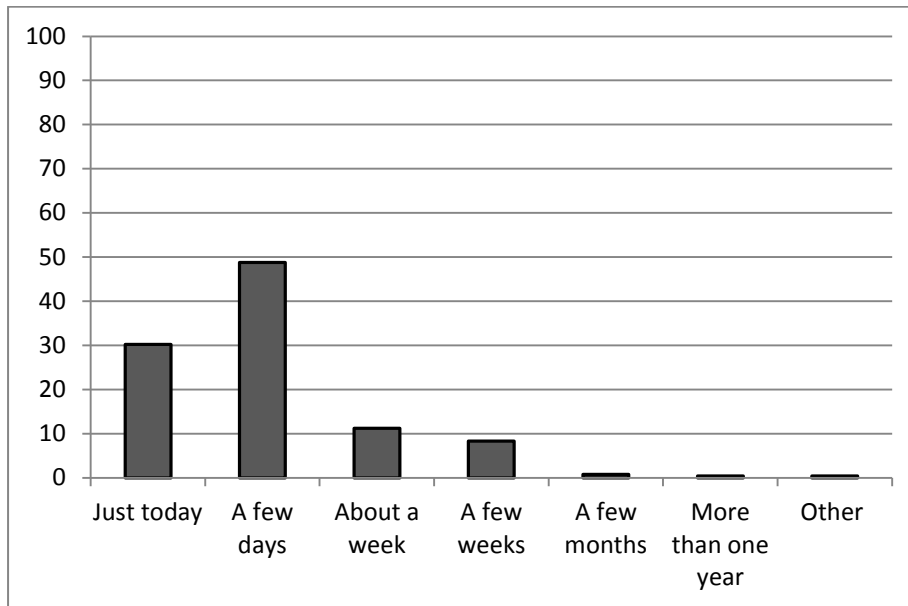
Respondents expected<sup>7</sup> that they would receive advice (62%), information (46%), treatment (31%), medication (27%), or a prescription (23%) when they attended the Walk-in Centre. Some respondents also thought they would receive a medical certificate (7%), be referred to a GP (9%), or be referred to the Emergency Department (9%).

The majority of respondents had the problem they presented with from one to a few days (Figure 24). Ten percent of respondents had seen a health care provider for the same problem in the previous four weeks, and 19% had seen a health care provider for another problem in the previous four weeks.

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<sup>7</sup> Respondents could choose more than one response

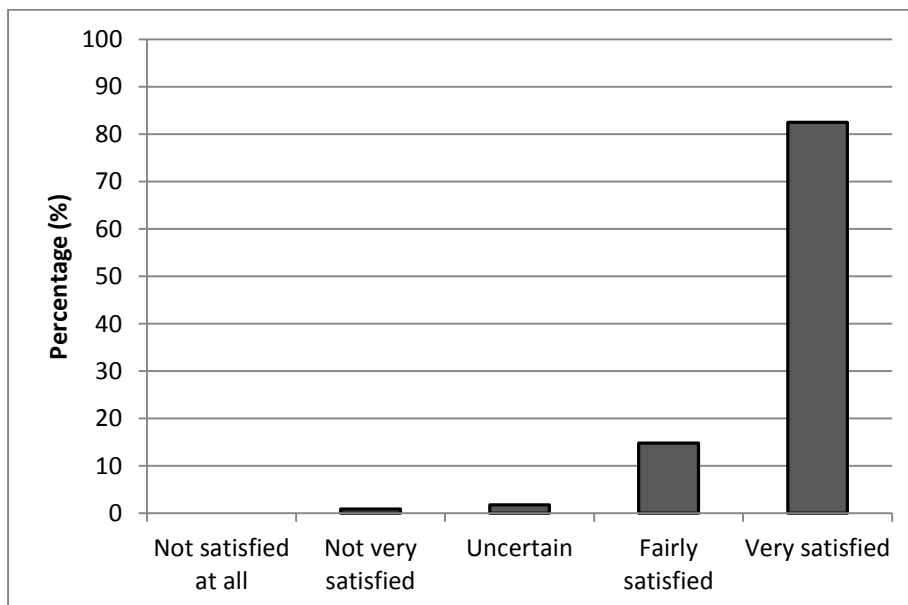
Figure 24: Duration of problem (n = 242)



### Satisfaction

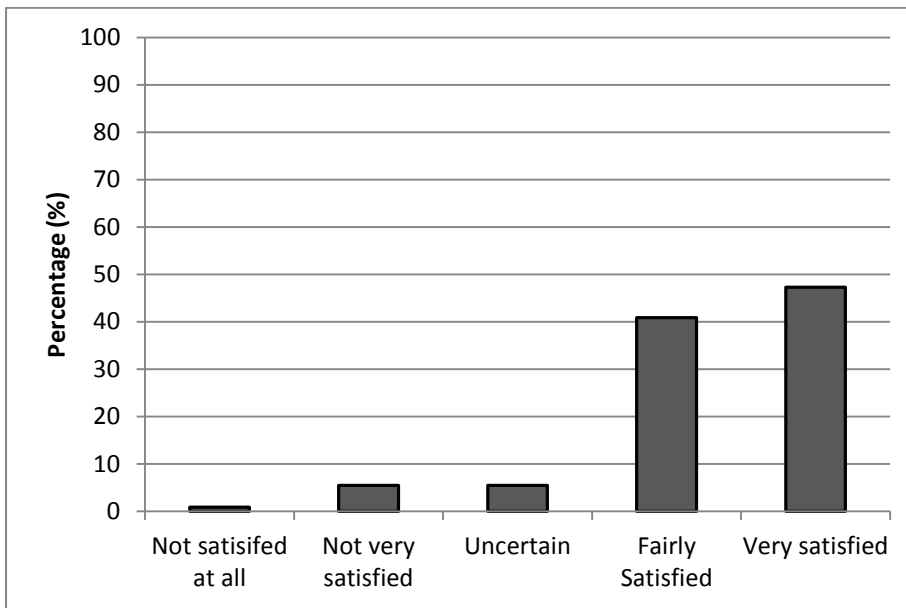
After the respondents had consulted with a nurse at the Walk-in Centre, they were asked to rate how satisfied they were with various aspects of their experience. The majority (83%) of respondents were very satisfied with the attitude of the receptionist (Figure 25).

Figure 25: Respondents' satisfaction with the attitude of the receptionist (n=223)



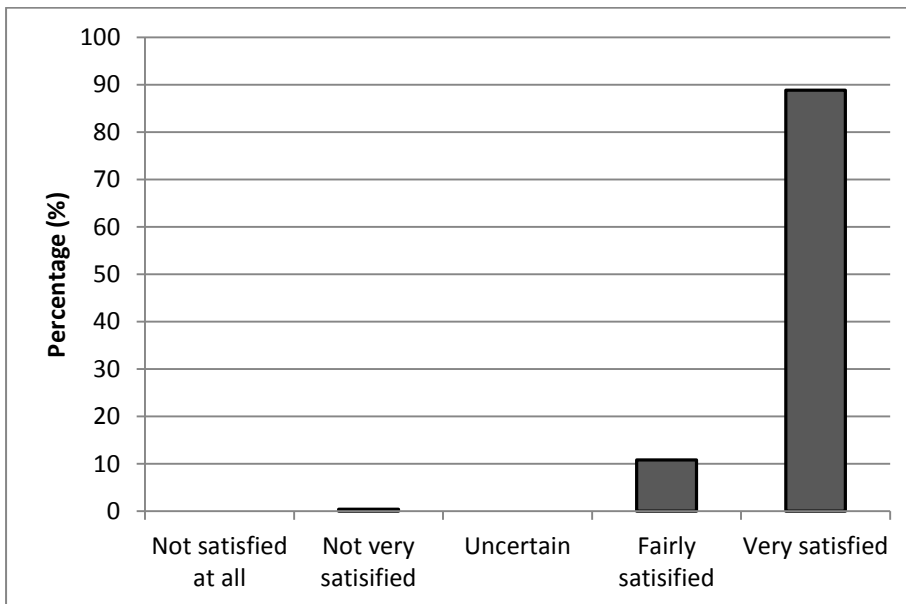
Most respondents were either fairly satisfied (41%) or very satisfied (47%) with the time they had to wait to see a nurse at the Walk-in Centre (Figure 26).

**Figure 26: Respondents' satisfaction with the time they had to wait to see a nurse at the Walk-in Centre (n=220)**



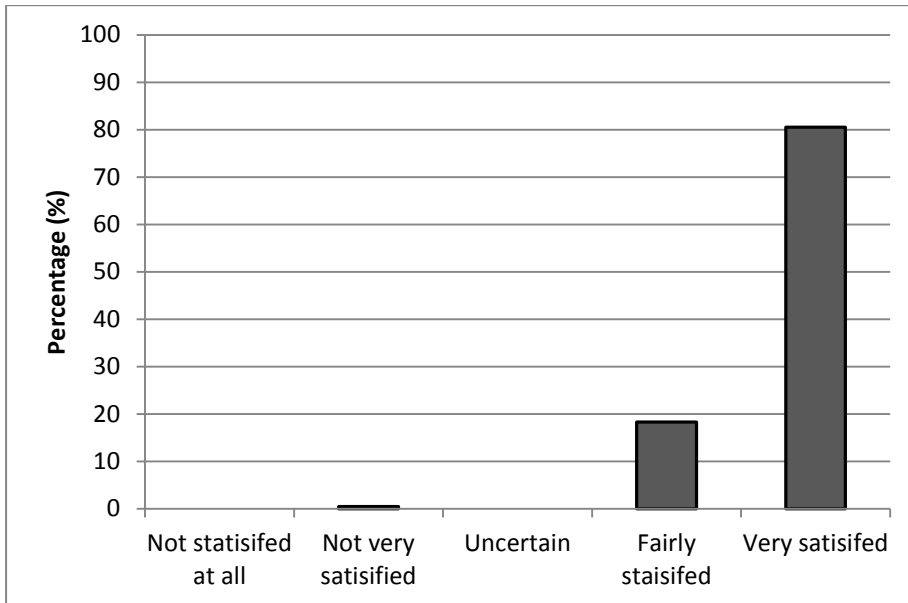
The majority of respondents were very satisfied (89%) or fairly satisfied (11%) with the attitude of the nurse (Figure 27).

**Figure 27: Respondents' satisfaction with the attitude of the nurse (n=223)**



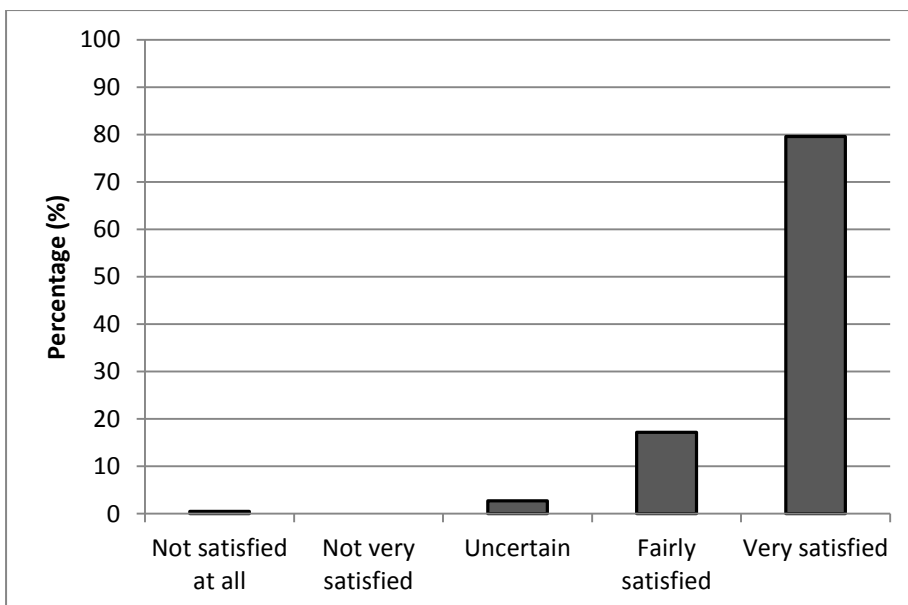
The majority of respondents were very satisfied (81%) or fairly satisfied (18%) with the explanation the nurse gave about their problem (Figure 28).

**Figure 28: Respondents' satisfaction with the explanation the nurse gave about their problem (n=220)**



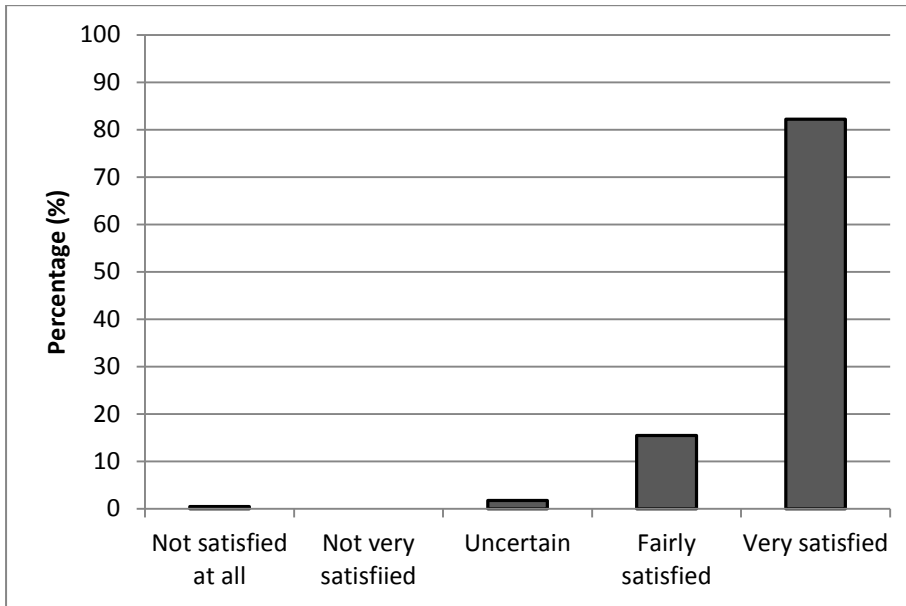
The majority of respondents were very satisfied (80%) or fairly satisfied (17%) with the treatment or advice the nurse gave them (Figure 29).

**Figure 29: Respondents' satisfaction with the treatment or advice given by the nurse (n=221)**



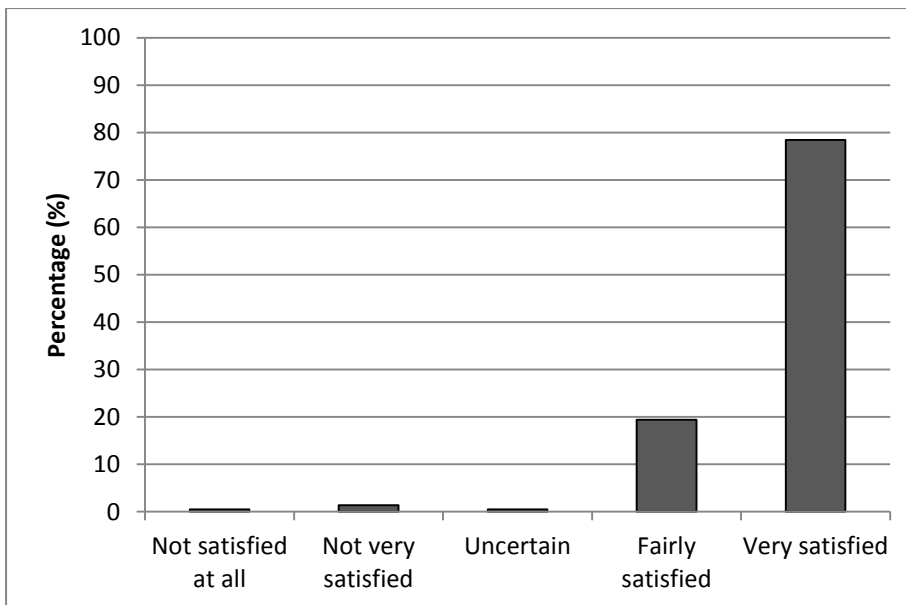
The majority of respondents were very satisfied (82%) or fairly satisfied (16%) with the length of time they spent with the nurse (Figure 30).

**Figure 30: Respondents' satisfaction with the length of time they spent with the nurse (n=219)**



Overall, the majority of respondents were very satisfied (78%) with the service they received at the Walk-in Centre (Figure 31).

**Figure 31: Respondents' overall satisfaction with the service they received at the Walk-in Centre (n=222)**



## Relationships between satisfaction and patient characteristics

The patient characteristics were compared with the different aspects of the service to examine the percent of patients who were very satisfied with each aspect. There were no significant relationships which predicted satisfaction with the attitude of the reception staff. In contrast, with regard to waiting time, parents of children were significantly more likely to be highly satisfied compared with the other respondents (OR 23.87,  $p=0.02$ ) (Table 8).

**Table 8: Comparison between the type of patient and whether they were very satisfied with different aspects of service**

Very satisfied with:	Myself % (n total)	My Child % (n total)	Other % (n total)	Total % (n total)
Attitude of the receptionist	79.1% (163)	90.4% (52)	80.0% (10)	81.7% (225)
Waiting time to see a nurse	46.9% (162)	52.9% (51)	55.6% (9)	48.2% (222)
Attitude of the nurse	90.0% (163)	86.5% (52)	80.0% (10)	88.0% (225)
Explanation given by nurse	79.0% (162)	86.0% (50)	80.0% (10)	80.6% (222)
Treatment or advice given by nurse	76.5% (162)	88.2% (51)	70.0% (10)	78.9% (223)
Length of time spent with nurse	77.7% (162)	88.0% (50)	80.0% (10)	80.1% (222)
Overall satisfaction with service	76.7% (163)	84.3% (51)	80.0% (10)	78.6% (224)

Age accounted for a number of significant relationships. Older patients were significantly more likely to be very satisfied with the explanation the nurse gave about the problem (OR 1.67,  $p=0.048$ ), with the treatment or advice given by the nurse (OR 1.90,  $p=0.01$ ), and very satisfied with the overall service (OR 1.86,  $p=0.01$ ) (Table 9).

**Table 9: Comparison between patients' age and whether they were very satisfied with different aspects of service**

	0 – 9 yrs % (n total)	10 – 19 yrs % (n total)	20- 29 yrs % (n total)	30 – 39 yrs % (n total)	40 – 49 yrs % (n total)	50 – 59 yrs % (n total)	60+ yrs % (n total)	Total % (n total)
Attitude of the receptionist	88.8% (27)	91.1% (45)	69.2% (52)	67.6% (34)	85.7% (35)	92.3% (13)	94.1% (17)	81.6% (223)
Waiting time to see a nurse	42.3% (26)	52.3% (42)	41.5% (53)	52.9% (34)	51.4% (35)	61.5% (13)	41.2% (17)	48.2% (220)
Attitude of the nurse	92.6% (27)	80.0% (45)	86.8 (53)	88.2% (34)	94.1% (34)	84.6% (13)	94.1% (17)	87.9% (223)
Explanation given by nurse	80.7% (26)	84.4% (45)	71.7.6 % (53)	88.2% (34)	78.8% (33)	76.9% (13)	87.5% (16)	80.5% (220)
Treatment or advice given by nurse	84.0% (25)	80.0% (45)	67.9% (53)	88.2% (34)	78.8% (33)	76.9% (13)	88.2% (17)	78.7% (221)
Length of time spent with nurse	76.0% (25)	84.4% (45)	72.2% (54)	88.2% (34)	78.7% (33)	76.9% (13)	87.5% (16)	80.0% (220)
Overall satisfaction with service	76.9% (26)	80.0% (45)	67.9% (53)	82.4% (34)	82.4% (34)	84.6% (13)	88.2% (17)	78.4% (222)

Patients who were born in Australia were significantly more likely to be very satisfied with the explanation the nurse gave about the problem (OR 6.01,  $p=0.02$ ) and the treatment or advice given by the nurse (OR 7.20,  $p=0.01$ ) than patients who were born in other countries (Table 10).

**Table 10: Comparison between patients' country of birth and whether they were very satisfied with different aspects of service**

Satisfied with	Australia	Other	Total
Attitude of the receptionist	84.7% (183)	61.7% (47)	81.7% (225)
Waiting time to see a nurse	49.2% (179)	41.9% (43)	48.2% (222)
Attitude of the nurse	88.5% (183)	85.7% (42)	88.0% (225)
Explanation given by nurse	82.7% (181)	66.7% (42)	80.6% (222)
Treatment or advice given by nurse	82.1% (181)	69.1% (42)	78.9% (223)
Length of time spent with nurse	82.9% (181)	70.7% (41)	80.25% (222)
Overall satisfaction with service	79.7% (182)	76.2% (42)	78.6% (224)

Patients who had a secondary education were significantly more likely to be satisfied with the waiting time (OR 0.11,  $p=0.01$ ) compared to those who had a pre-primary or primary education (Table 11).

**Table 11: Comparison between patients' education and whether they were very satisfied with different aspects of service**

Satisfied with	Pre-primary/Primary	Secondary	Vocational	Tertiary or Postgraduate	Total
Attitude of the receptionist	87.2% (39)	86.0% (50)	80.0% (70)	76.9% (65)	81.7% (225)
Waiting time to see a nurse	37.8% (37)	51.0% (49)	58.0% (70)	36.4% (66)	48.2% (222)
Attitude of the nurse	84.6% (39)	89.8% (49)	85.7% (70)	90.9% (66)	88.0% (225)
Explanation given by nurse	81.6% (38)	81.3% (48)	84.3% (70)	75.4% (65)	80.6% (222)
Treatment or advice given by nurse	84.2% (38)	85.7% (49)	81.4% (70)	67.7% (65)	78.9% (223)
Length of time spent with nurse	81.1% (38)	85.7% (49)	81.4% (70)	69.7% (66)	80.2% (222)
Overall satisfaction with service	84.2% (38)	85.7% (49)	78.6% (70)	69.7% (66)	78.5% (224)



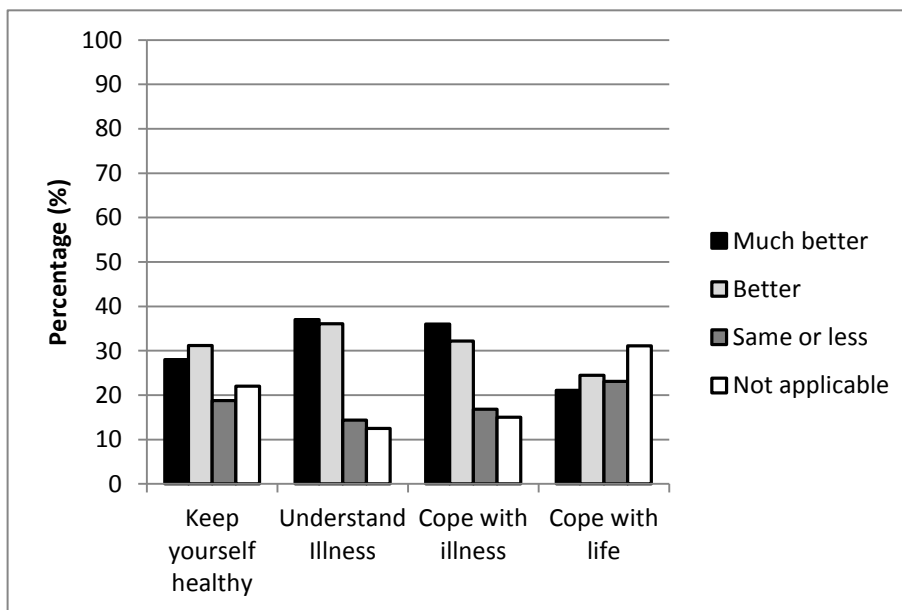
## Outcome of a consultation with a nurse

When respondents saw the nurse, they reported that they received:<sup>8</sup>

- > Advice (58%)
- > Information (48%)
- > A prescription (6%)
- > Medication (23%)
- > Treatment other than a medication (37%)
- > They were referred to a GP (16%)
- > They were referred to the Emergency Department (3%)
- > They were referred to CALMS (2%)
- > Other (10%):
  - Medical certificate (n=11)
  - X ray (n=8)
  - Referred to physio (n=1)
  - Referred to falls clinic (n=1)

As a result of seeing the nurse at the Walk-in Centre, respondents felt that they were much better (28%) or better (31%) able to keep themselves healthy (n=218), much better (37%) or better (36%) able to understand their illness (n=216), much better (36%) or better (32%) able to cope with their illness (n=214), and much better (21%) or better (25%) able to cope with life (n=212) (Figure 32).

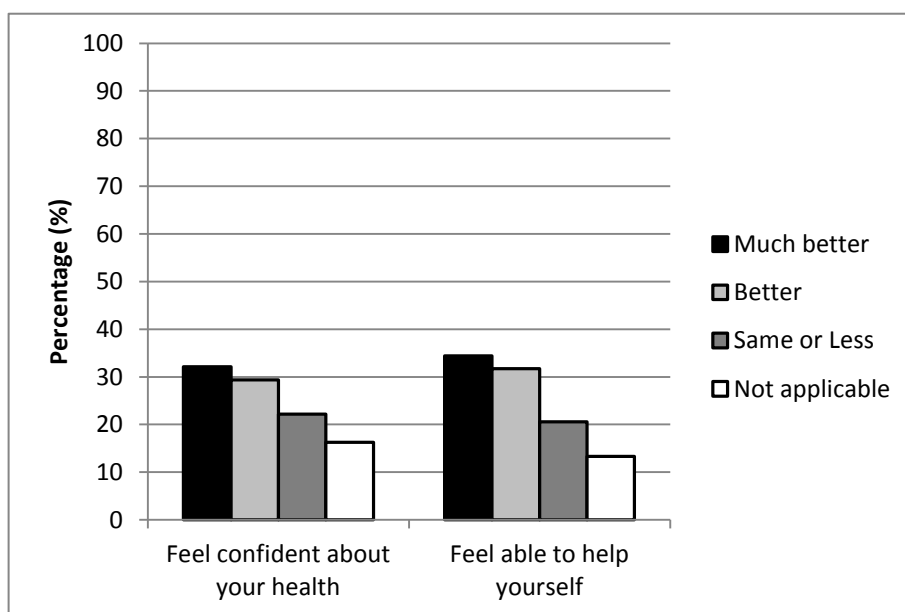
**Figure 32: Respondents' feelings after they had seen the nurse at the Walk-in Centre with regard to keeping healthy, understanding illness, coping with illness and coping with life n=218**



<sup>8</sup> Respondents could choose more than one response

As a result of seeing the nurse at the Walk-in Centre, respondents felt much better (32%) or better (30%) in feeling confident about their health (n=220), and much better (34%) or better (32%) in feeling able to help themselves (n=217) (Figure 33).

**Figure 33: Respondents' feelings after they had seen the nurse at the Walk-in Centre with regard to feeling confident about their health and feeling able to help themselves n=217**



Once they had consulted with a nurse at the Walk-in Centre, 33% were going to seek no further treatment or advice, 31% reported they would deal with the problem themselves, and 22% were going to make an appointment with their GP. A further 6% were going to visit the Emergency Department, and 4% were going to visit CALMS.

The majority of respondents left the Walk-in Centre (96%) without any unanswered questions. Eighty-three percent would definitely and 16% would probably recommend the Walk-in Centre to family and friends. Eighty-two percent would definitely and 16% would probably use the Walk-in Centre again.

## DISCUSSION

This survey has demonstrated that the majority of patients are satisfied with the ACT Health Walk-in Centre. Age played a significant role in regard to satisfaction with different aspects of the Walk-in Centre; older patients were more satisfied with the explanation, treatment and advice that the nurse gave, and had a higher overall satisfaction with the service. Country of birth also contributed to satisfaction, with patients born in Australia being significantly more satisfied with the explanation, treatment and advice that the nurse gave, than patients born elsewhere. This may be reflective of language or cultural aspects of the nature of the explanation and advice provided by the nurses which may not have been adequate for patients who were born in a country other than Australia.

Waiting time was the only aspect of satisfaction that did not receive as high percentages of 'very satisfied' compared with the other aspects. This aspect of the service may become more concerning in the future if the Walk-in Centre's patient population continues to grow as has been evidenced in the first year. This may cause an increase in the time patients have to wait for a consultation with a nurse, thereby reducing this aspect of satisfaction further. In addition, as is consistent with the findings from the audit of the CDSS, the waiting time recorded by the CDSS software may not be a true reflection of the time patients wait, which may be why many patients were only fairly satisfied with the wait time despite the average time being under 20 minutes.

The Walk-in Centre's opening hours and location were convenient for respondents and one third had used the Walk-in Centre previously. This is also testament to their satisfaction with the service as these respondents were willing to return and use the Walk-in Centre again for episodic care. The accessibility of the Walk-in Centre was highlighted by respondents using the service as an alternative to a GP or the Emergency Department due to being able to access a consultation in a more timely manner. However, respondents did note that if the Walk-in Centre had not been available, they would have gone to the GP or the Emergency Department, and a further 14% would have looked after the problem themselves. This latter group may contribute to the perception that the Walk-in Centre is creating demand rather than servicing a need in the community. Furthermore, 22% of the respondents reported that they were going to seek an appointment with their GP after seeing a nurse at the Walk-in Centre.

Individuals who went to the Walk-in Centre seeking care and were out of scope and were therefore unable to be registered for the service and redirected to another health care service, were not included in this survey. These individuals' experience is as valid and as important as those who were surveyed, and it is possible that their satisfaction with some aspects of the service was not as high as the survey respondents. In order to capture these individuals' perspectives and provide them with the opportunity to give their views, the methodology used for the recruitment of the survey would need to be changed to approach individuals prior to registration at the Walk-in Centre reception.

The patient satisfaction with the Walk-in Centre is high and suggests that a quality service is being provided to the community. However, there was no scope for comparison to other health care providers in this evaluation and therefore, it is unknown whether the patients attending the Walk-in Centre are any more or less satisfied than those who attended other health care services. This is a major limitation of this survey and satisfaction needs to be measured and compared to services in the ACT providing comparable primary care services such as GPs and the Emergency Department to provide a fair assessment of the quality of the Walk-in Centre service.



# Chapter 4 Walk-in Centre Nurse Satisfaction: Index of Work Satisfaction survey

## INTRODUCTION

Understanding the views and levels of satisfaction of the clinical nursing staff employed at the ACT Health Walk-in Centre provide an important insight into their experience of working the Walk-in Centre and providing patient care. In order to examine the nurses' experience of working at the ACT Health Walk-in Centre, two approaches were used. The first is the use of the Index of Work Satisfaction tool which is a validated instrument designed to assess nurses' satisfaction with their workplace.<sup>24</sup> The second is a qualitative approach, where the clinical nursing staff were invited to participate in a face-to-face interview to further explore their experiences of working at the Walk-in Centre and their satisfaction with various aspects of their work. This chapter presents the results from the Index of Work Satisfaction tool and Chapter 5 presents the findings from the qualitative interviews with the Walk-in Centre nurses.

## METHODS

Ethics approval to survey the nursing staff at the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.10.407) on the 15<sup>th</sup> December 2010 and subsequently given expedited approval by The Australian National University Human Research Ethics Committee on the 22<sup>nd</sup> December 2010 (protocol no. 2010/649).

### Design

The Index of Work Satisfaction is a validated measurement tool designed to assess nurses' satisfaction with their workplace.<sup>24</sup> The tool assesses six components of satisfaction: pay, autonomy, task requirements, organisation policies, professional status, and interaction between nurses and between nurses and physicians. The tool is comprised of parts A and B, where part A asks respondents to compare and rank each component to create a hierarchy of the components and results in a Component Weighting Coefficient. Part B consists of 44 items which are attitude statements categorised to each component, and are either positively or negatively worded. Respondents are asked to score each item using a 7-point scale that ranges from strongly agree to strongly disagree.

This tool was considered suitable for use with the nurses employed at the ACT Health Walk-in Centre, however some modifications were required as the tool was originally designed for nurses employed in a hospital setting. The author of the Index of Work Satisfaction, Professor Paula Stamps, gave her approval to the modifications made to the tool. These included removing three items from the pay component, one from the organisational policies component, one from the professional status component, and one from the interaction: nurses – physicians component, which were irrelevant to the Walk-in Centre context (Table 12). Instead, an additional six items were included in the interaction: nurses – physicians component, which was renamed interaction: nurses – external health providers, to examine the interaction between the nurses at the Walk-in Centre and general practice and emergency department staff. The wording of many items was also modified to reflect the context and staffing of the ACT Health Walk-in Centre.

**Table 12: Items removed from the Index of Work Satisfaction tool and newly included to match the scope of the ACT Health Walk-in Centre**

<b>Removed items</b>	<b>Included items</b>
It is my impression that a lot of nursing service personnel at this hospital are dissatisfied with their pay.	I wish the medical staff in the emergency department would show more respect for the skill and knowledge of the nursing staff at the walk-in centre.
The present rate of increase in pay for nursing personnel at this hospital is not satisfactory.	GPs look down too much on the nursing staff at the walk-in centre.
From what I hear about nursing service personnel at other hospitals, we at this hospital are being fairly paid.	Emergency department medical staff are cooperative with nurses at the walk-in centre.
There are not enough opportunities for advancement of nursing personnel at this hospital.	Practice nurses are cooperative with nurses at the walk-in centre.
Most people appreciate the importance of nursing care to hospital patients.	Emergency department nurses are cooperative with nurses at the walk-in centre.
There is a lot of teamwork between the nurses and doctors on my unit.	Doctors in the emergency department generally understand and appreciate what the nurses at the walk-in centre do.

### Recruitment

All clinical nursing staff at the walk-in centre (n=13) were invited to participate in this project. Information about the project and participation was sent to nursing staff via email. Those staff willing to participate in the project contacted the research team via email or telephone to arrange a time and date to participate.

### Data collection

Nursing staff who agreed to participate were asked to complete the two part modified Index of Work Satisfaction tool prior to participating in a face-to-face interview.

## RESULTS

Twelve nurses completed the Index of Work Satisfaction Tool prior to their qualitative interview (Table 13). The nurses were mostly female which reflects the gender divide of the nursing staff at the ACT Health Walk-in Centre. The nurses had a minimum of 15 years of nursing experience and were evenly split between working part time or full time.

**Table 13: Demographics of respondents (n=12)**

<b>Characteristic</b>	<b>n (%)</b>
Gender	
Male	1 (8%)
Female	11 (92%)
Advanced practice nurse	8 (67%)
Nurse practitioner	3 (25%)
Both	1 (8%)
Age (years)	
Mean	46.4
Median (range)	47 (31 – 62)
Years of experience	
Mean	23.1
Median (range)	25 (15 – 41)
Employed at the Walk-in Centre	n (%)
Full time	6 (50%)
Part time	6 (50%)
Hours worked per fortnight at the Walk-in Centre	
8	1
24	1
32	1
40	1
48	1
64	1
76	4
80	1
missing	1
Practices elsewhere in addition to the Walk-in Centre	1 (8%)
Number of hours worked in other location	32

The responses to the Index of Work Satisfaction were scored to determine a Component Weighting Coefficient for each component in Part A, which is an indication of how each respondent compared and ranked each component. This indicates that respondents ranked autonomy (4.26) as the most important component of satisfaction and pay as the least important component of satisfaction (2.20) (Table 14).

The attitude scale in Part B was scored by calculating the average score for each item within each component. These average scores were summed to give the Component Scale Score, which was then averaged according to the number of items to give the Component Mean Score. The range for the mean scores is from 1 (least satisfied) to 7 (most satisfied), therefore indicating that respondents were most satisfied with professional status (5.50) and least satisfied with the organisational policies (2.60) of the ACT Health Walk-in Centre (Table 14).

The Component Adjusted Scores for each component is the weighted score of the satisfaction of each component (Component Mean Score) by the level of importance placed on each component (Component Weight Coefficient). This demonstrates that respondents perceive that their professional status (19.80) and autonomy (17.38) are the most important and satisfying aspects of their role (Table 14).

**Table 14: Index of Work Satisfaction score**

<b>Component</b>	<b>Component Weighting Coefficient</b>	<b>Component Scale Score</b>	<b>Component Mean Score</b>	<b>Component Adjusted Scores</b>
Pay	2.20	16.42	5.47	12.03
Autonomy	4.26	33.67	4.08	17.38
Task requirements	2.58	27.25	4.54	11.71
Organisational policies	2.60	15.58	2.60	6.76
Professional status	3.60	33.05	5.50	19.80
Interaction	3.33	56.83	3.79	12.62
Internal nurses	-	26.50	5.30	-
External health providers	-	30.33	3.03	-
Total Scale Score: 239.05 (range: 44 – 308)				
Mean Scale Score: 5.43 (range: 1 – 7)				
IWS: 13.38 (range: 0.9 – 37.1)				

Examining the items within each component demonstrates the aspects of the role that are least or most satisfying (Table 15). For example, for the organisational policies of the ACT Health Walk-in Centre, the nurses are largely dissatisfied with their opportunities to participate in the administrative decision-making process, did not perceive they had a voice in planning policies and procedures for the walk-in centre, and agreed that there is a great gap between the administration of the walk-in centre and the daily issues of the nursing staff.

While the nursing staff ranked pay as a component that was not as important compared to the other components, their levels of satisfaction with their pay were evident in agreeing that their present wage is satisfactory and that the pay they get is reasonable.

The nurses' internal interaction was generally satisfactory, however there was some dissatisfaction evident regarding the perceived difficulties new nurses encounter in feeling 'at home' in the Walk-in Centre, and that the other nurses at the Walk-in Centre are not as friendly and outgoing as would be preferred. Additionally, while the majority of nurses agreed that their colleagues would pitch in and help one another out when things are busy, there was less agreement that there was a good deal of teamwork and cooperation between the CNC, the nurse practitioners and the advanced practice nurses at the walk-in centre.

With regards to the interaction of the ACT Health Walk-in Centre nursing staff with external health care providers in general practice and the emergency department, the respondents were less satisfied. The majority of respondents disagreed that the emergency department medical staff are cooperative and generally understand and appreciate what the nurses at the walk-in centre do. The respondents also disagreed that the emergency department nurses are cooperative with nurses at the ACT Health Walk-in Centre. In addition, the majority of respondents agreed that the doctors in the emergency department look down too much on the nursing staff at the ACT Health Walk-in Centre, and they wished that they would show more respect for the skill and knowledge of the nursing staff at the ACT Health Walk-in Centre.

In contrast, the respondents were less certain of their interactions with general practice staff, including general practitioners. Responses were spread but respondents were generally dissatisfied in their perception that GPs are not cooperative and generally do not understand and appreciate the nurses' role at the ACT Walk-in Centre. In contrast, respondents generally agreed that practice nurses were cooperative with nurses at the ACT Walk-in Centre.



Table 15: Frequency distribution of responses to the Index of Work Satisfaction

	Strongly agree	Agree	Moderately agree	Undecided	Moderately disagree	Disagree	Strongly disagree
<b>PAY</b>							
My present wage is satisfactory.	33%	50%	0	17%	0	0	0
Considering the service we provide, the pay we get is reasonable.	25%	50%	17%	0	8%	0	0
An upgrading of pay schedules is needed for nurses working at the walk-in centre.	0	8%	17%	25%	8%	42%	0
<b>AUTONOMY</b>							
I feel I am supervised more closely than is required.	8%	17%	0	8%	17%	42%	8%
I have too much responsibility and not enough authority.	0	17%	25%	17%	8%	33%	0
At the walk-in centre, the supervisors make all the decisions. I have little direct control within my own workplace.	25%	8%	25%	8%	17%	17%	0
I am sometimes frustrated because all of my activities seem programmed for me.	17%	8%	8%	17%	17%	25%	8%
I am sometimes required to do things in my job that are against my better professional nursing judgement.	8%	17%	25%	8%	0	17%	25%
I feel I have sufficient input into the program of care for each of my patients.	0	25%	42%	8%	25%	0	0
A great deal of independence is permitted, if not, required of me.	8%	25%	42%	8%	0	17%	0
I have the freedom in my work to make important decisions as I see fit, and can count on my supervisors to back me up.	0	8%	0	8%	42%	8%	33%
<b>TASK REQUIREMENTS</b>							
There is too much clerical and paperwork required of nursing staff at the walk-in centre.	8%	33%	33%	0	25%	0	0
I think I could do a better job if I did not have so much to do all the time.	0	17%	8%	8%	58%	8%	0
I could deliver much better care if I had more time with each patient.	0	0	8%	8%	25%	42%	17%
I am satisfied with the types of activities that I perform in my job.	0	25%	50%	0	17%	8%	0
I have plenty of time and opportunity to discuss patient care problems with other nurses at the walk-in centre.	8%	0	42%	0	33%	17%	0
I have sufficient time for direct patient care.	33%	42%	8%	0	17%	0	0
<b>ORGANISATIONAL POLICIES</b>							

	Strongly agree	Agree	Moderately agree	Undecided	Moderately disagree	Disagree	Strongly disagree
The nurses have sufficient control over scheduling their own shifts at the walk-in centre.	17%	0	8%	17%	8%	25%	25%
There is ample opportunity for the nurses to participate in the administrative decision-making process.	0	8%	0	0	17%	42%	33%
I have all the voice in planning policies and procedures for the walk-in centre that I want.	0	8%	8%	0	8%	33%	42%
The nursing administrators generally consult with the walk-in centre nurses on daily problems and procedures.	0	0	0	0	42%	8%	50%
There is a great gap between the administration of the walk-in centre and the daily issues of the nursing staff.	25%	33%	8%	25%	8%	0	0
Administrative decisions at the walk-in centre interfere too much with patient care.	17%	8%	25%	17%	33%	0	0
<b>PROFESSIONAL STATUS</b>							
Nursing is not widely recognised as being an important profession. (n=11 responses)	9%	27%	27%	9%	0	18%	9%
What I do in my job does not add up to anything really significant.	0	0	8%	0	25%	17%	50%
My particular job does not require much skill or 'know-how'.	0	0	0	0	0	17%	83%
There is no doubt in my mind that what I do in my job is really important.	33%	33%	17%	8%	8%	0	0
It makes me proud to talk to other people about what I do in my job.	0	25%	25%	25%	17%	8%	0
If I had the decision to make all over again, I would still go into nursing.	58%	33%	8%	0	0	0	0
<b>INTERACTION: INTERNAL NURSES</b>							
It is difficult for new nurses to feel 'at home' in the walk-in centre.	0	8%	8%	17%	17%	25%	25%
The other nurses at the walk-in centre are not as friendly and outgoing as I would like.	0	0	8%	0	25%	8%	58%
There is significant 'rank consciousness' between the CNC, the nurse practitioners and the advanced practice nurses at the walk-in centre.	8%	17%	0	8%	25%	8%	33%
The nurses at the walk-in centre pitch in and help one another out when things get busy.	42%	42%	8%	0	8%	0	0
There is a good deal of teamwork and cooperation between the CNC, the nurse practitioners and the advanced practice nurses at the walk-in centre.	0	33%	25%	8%	17%	8%	8%

	Strongly agree	Agree	Moderately agree	Undecided	Moderately disagree	Disagree	Strongly disagree
<b>INTERACTION: EXTERNAL HEALTH PROVIDERS</b>							
I wish GPs would show more respect for the skill and knowledge of the nursing staff at the walk-in centre.	17%	25%	25%	25%	8%	0	0
GPs look down too much on the nursing staff at the walk-in centre.	8%	8%	8%	33%	25%	17%	0
I wish the medical staff in the emergency department would show more respect for the skill and knowledge of the nursing staff at the walk-in centre.	58%	25%	0	8%	0	8%	0
The doctors in the emergency department look down too much on the nursing staff at the walk-in centre.	17%	42%	8%	17%	8%	8%	0
GPs are cooperative with nurses at the walk-in centre.	0	0	8%	42%	25%	17%	8%
GPs generally understand and appreciate what the nurses at the walk-in centre do.	0	8%	0	25%	8%	50%	8%
Practice nurses are cooperative with nurses at the walk-in centre.	0	17%	50%	33%	0	0	0
Emergency department medical staff are cooperative with nurses at the walk-in centre.	0	8%	17%	8%	0	42%	25%
Doctors in the emergency department generally understand and appreciate what the nurses at the walk-in centre do.	0	0	17%	0	8%	42%	33%
Emergency department nurses are cooperative with nurses at the walk-in centre.	8%	8%	0	0	25%	33%	25%



# Chapter 5 Walk-in Centre Nurse Satisfaction: Qualitative Interviews

## INTRODUCTION

Studies of nurses' job satisfaction are performed for a number of purposes, mostly overlapping between research and management.<sup>25</sup> Management purposes are often to evaluate programs of patient care, organisational communication systems, management systems and nursing retention.<sup>25</sup> Generally, studies examining the nature of nurses' job satisfaction often have the purpose of developing strategies to improve nurse retention rates or perhaps to enhance recruitment.

Herzberg's dual factor theory of job satisfaction refers to factors which lead to satisfaction and those which lead to dissatisfaction<sup>26</sup> This is the theory most often used in nursing research. Vroom (1964) referred to work satisfaction in terms of the degree to which one's needs are met in the workplace<sup>27</sup> Higher levels of nurse job satisfaction are associated with increases in morale and commitment and subsequently nurse retention.<sup>28</sup> It is also associated with improved quality of nursing care and positive outcomes for patients and health care providers.<sup>29-31</sup>

National and international literature is rich with research regarding nurse job satisfaction in the acute care sector. However, nurse job satisfaction in primary care and in particular, with working in nurse-led roles and in Walk-in Centres has only been observed in the United Kingdom.<sup>32</sup>

### Aim

The aim of this study is to gain insight into the nursing staff's perceptions of, and satisfaction with working at the ACT Health nurse led Walk-in Centre.

### Design

Satisfaction amongst nurses working at the ACT Health Walk-in Centre was measured in terms of dependent and independent variables identified by Hayes (2010).<sup>33</sup> These are inter-personal, extra-personal and intra-personal factors. Inter-personal factors relate to interactions between the nurse and others. They include autonomy, direct patient care, professional relationships, roster management, positive leadership and respect from supervisors, educational opportunities and professional pride. Extra-personal factors are those beyond a nurse's direct interactions with others and are influenced by institutional or governmental policies: pay, organisational policies affecting staffing levels, repetitiveness or routinisation and organisational budgetary constraints. Intra-personal factors refer to the characteristics nurses bring to the workplace: individual coping strategies, age, education and period of time working in an area.<sup>33</sup>

A secondary influence on the nature of enquiry and analysis of data regarding nursing satisfaction in the Walk-in Centre is the fact that this is a new and innovative nursing role. The ways in which nurses transitioned to, and negotiated challenges to this role, and sources of role stress were of interest in this study; that is, what works and what doesn't work in the role. Handy (1993) used the concept of role theory to understand and predict the performance and behaviour of people in the workplace.<sup>34</sup> Within the above identified variable factors, principles of role theory informed the design of the semi-structured interviews. (See Appendix B).

The qualitative research method employed was phenomenology; concerned with the study of experience from the perspective of the individual, their lived experience, and subjective analysis of that experience.<sup>35</sup>

# METHODS

Ethics approval to interview the nursing staff at the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.10.407) on the 15<sup>th</sup> December 2010 and subsequently given expedited approval by The Australian National University Human Research Ethics Committee on the 22<sup>nd</sup> December 2010 (protocol no. 2010/649).

## Recruitment

All clinical nursing staff at the Walk-in Centre (n=13) were invited to participate in this project. Information about the project and participation was sent to nursing staff via email. Those staff willing to participate in the project contacted the research team via email or telephone to arrange a time and date to participate.

## Data collection

Participation comprised a face-to-face interview after completing the Index of Work Satisfaction survey tool. Nursing staff were required to sign a consent form prior to participating. Completion of the interview took place at various times and locations determined as convenient to participants, with consideration made for privacy.

Interviews were audio-recorded and transcribed verbatim. Written consent was provided by each participant prior to interview. All identifying information about the participants was removed from the transcripts prior to analysis.

Interviews were conducted throughout February and early March 2011.

## Data analysis

Interviews with each nurse were conducted by a member of the research team. They were recorded and transcribed, and any identifying information about the participants removed. NVivo 8 software (QSR International Pty Ltd., Melbourne, Australia) was used to manage the data and facilitate coding. Transcripts were analysed with a focus on identifying ideas, concepts and patterns, and the way in which they fell within identified intra, extra and interpersonal variables. An inductive approach was used for analysis similar to that described by Braun and Clarke,<sup>36</sup> which involved reading and re-reading the transcripts; assigning of codes to sections of the transcript to categorise the data into themes and ideas; and comparison of these themes for similarities, relationships and tensions.

## Data storage

The data collected for this phase of the project were in electronic audio and paper format. Data were stored electronically and in secure file cabinets. Only the APHCRI research team has access to these data. Data will be stored for a minimum of five years from the date of the final publication.

# RESULTS

Twelve nurses agreed to participate in the study. A number of themes emerged, which fell within the three variables; inter-, intra-, and extra-personal. Within each variable areas of satisfaction and sources of stress were described; some themes ran across more than one variable.

## Interpersonal factors

### *Relationships with other health care providers*

Doctors in the Emergency Department (ED) and The Canberra Hospital (TCH)

Participants' descriptions of their relationships with medical staff within the hospital were mixed. Whilst incidents were described when medical staff had been uncooperative or difficult to communicate with, a number of participants perceived this as being related to frustration with Walk-in Centre protocols requiring the nurses to contact doctors with issues that were either un-resolvable by telephone, or inappropriate for referral. These encounters were, at times, distressing or professionally embarrassing; however, not all nurses perceived these incidents as overall resistance or as general or ongoing sources of stress:

*Respondent: I think there were times that we were required to send patients because of our disposition [protocol] to Emergency, and the Admitting Officers didn't feel it was appropriate and so they'd get a little bit stropky and we'd say well I agree with you, we don't really particularly feel it's necessary but we don't have a choice. So that was embarrassing I guess and probably made them a bit stropky.*

*Respondent: So we contact them [a specialty registrar as per protocol] and then they say, "well send them to the Emergency; I can't see them so I can't do it". So then you hang up and then you have to ring Emergency Department and they go, "well what do you want me to do about it?"*

*Respondent: Well, a few of the consultants, the admitting officers we have to phone them. So, a couple of them have been wonderful and some are absolutely appalling [laughs].*

Some of the issues had been resolved, such as those related to some Walk-in Centre protocols; others had learnt to manage over time through development of new approaches and a consolidation of relationships between medical and Walk-in Centre staff.

Canberra After Hours Locum Medical Service (CALMS) and general practitioners (GPs)

Overall the relationships with CALMS were identified as positive:

*Respondent: Fantastic. We've got a really good relationship with CALMS .... Oh, I think everybody does it differently but I always ring. Yeah, always ring and speak to reception up at CALMS who are the nurses and give them an idea of what's wrong and that's one good thing with CALMS is you can always follow up the patient afterwards so I always ring up and say what do you think it was? So it's a learning thing.*

*Respondent: We haven't had much dealings with GPs except that what is great is that they are referring in to our clinic now and so if they can't see a patient they recommend, and it's a minor thing, so to me that's, barriers are breaking down. It's really, that's wonderful. So we do have redirections. And someone was actually sent with a GP letter because she needed dressings over a weekend which I think that's fabulous ...*

### *Relationships with management*

Participants felt they were not kept abreast of changes and/or developments within the Walk-in Centre, many of which directly affected them. In particular, they expressed the belief that management's primary concern was with the performance expectations of the centre and related statistics as opposed to staff concerns and clinical issues:

*Respondent: Every meeting [is] graphed with how many patients we've seen. Did we beat last month's thing? We've hit a thousand, ten thousand patients ... It [is] just completely focussed on numbers.*

### **Ability to have input into the operation of the centre**

Some respondents felt they had the capacity to input into the operation of the Walk-in Centre and others the converse:

*Respondent: I think everybody's got a voice, everybody that works here has got a voice on how it operates and input, yeah. So definitely. And I don't think anybody's excluded. I don't think, they'll certainly listen, take it on board but that doesn't necessarily mean that they're going to pick it up and go with it*

*Respondent: I would say 70 percent of the staff verbally would talk about things that they feel we should be doing but only 30 percent will actually act on it, to take a part in developing something.*

When change did occur, some nurses expressed a perception that the management did not inform them of decisions or changes, which was an ongoing source of frustration and mistrust:

*Respondent: 'Cos things tend to happen and it's sort of a fait accompli, we don't actually get to hear why.*

A general lack of effective communication within the Walk-in Centre was a source of stress and tension:

*Respondent: It really spreads a lot of negativity because when we want to do something we're told we can't do it. We're not told why we can't do it and we're not given the justification or the history or the decisions that were made along the way to lead to that decision and so it's very, very autocratic and it doesn't fly ... I just wish we I guess, a more of a team approach when it comes to decisions that are being made that impact the clinic.*

### **The Team**

All participants identified their colleagues (the team) as their primary source of support. They uniformly identified the development of team relationships as the best aspect of the initial training program. These ongoing relationships were seen to sustain them throughout their initial transition to practice in the Walk-in Centre and in the face of resistance from other health care professionals:

*Respondent: I've had a sense that we were given these, you know the triage protocols and then the treatment protocols and it was a huge struggle initially to actually work with those. They're very complex and muddled and nothing flows very well so it was very challenging for all of us in the beginning and we were all seen in a goldfish bowl, all the scrutiny, which was appalling and I think, well I have survived because of my colleagues. So, we've been able to talk, we had a good teambuilding in the beginning and that allowed for really strong team support.*

*Respondent: Absolutely, we're very supportive of each other. And even the frustrations I have ... we still support each other because at the end of the day they're still trying to figure out, they're trying to do the best that they can do, and I recognise that.*



## Autonomy

Autonomy was identified as a challenge by most participants, who stated that they have adapted to this with time. In particular, the support of their colleagues has been important in the period of transition:

*Respondent: There's much more responsibility, sending a patient home that you're not entirely sure what's going to happen for them, you know, late at night there's nowhere else to refer them so you're sending them home, that responsibility is very scary sometimes.*

*Respondent : The whole autonomous practice has been the hardest thing. Not having someone there to back you up. Not having someone there to ask, I shouldn't say not having someone, not having a senior medical person, like a doctor, to consult with. That's the biggest change.*

*Respondent: I've never been in that position before where I've had to make a final decision and say to a patient or client whatever you call it, this is what's wrong with you and this is how you treat it and go home.*

Satisfaction and comfort with autonomy was conversely related to level of education or experience: nurse practitioners and more experienced nurses, while comfortable with autonomy, having worked autonomously in prior roles expressed a desire for a source of ongoing consultation and collaboration. Conversely, some advanced practice nurses with no post graduate tertiary qualifications expressed satisfaction with the level of autonomy available in the position and did not identify the need for consultative and collaborative relationships with medical staff:

*Respondent: I think that I would have a [doctor] involved for consultative processes. They don't have to be on-site but to have somebody to call, to have that kind of relationship, to bounce things off.*

*Respondent: I think that really it would be ideal if a GP was hired to consult amongst two or three clinics or there was some sort of formalised relationship established with CALMS so that during afterhours I could just call somebody up and say you know I've got this patient, what do you think about this, what do you think I should actually do, does this sound like a reasonable treatment plan for the interim*

*Respondent: ... I would say I haven't got a problem with my level of autonomy here. I can work independently. I certainly, you know you've got to work within your guidelines... but you've always got the opportunity of just bouncing concerns and stuff off other colleagues so I don't have a problem with that at all.*

## Capacity to deliver quality nursing care

Participants stated satisfaction with their ability to deliver quality nursing care at the Walk-in Centre. At the same time they believed that this would be enhanced if the scope of practice of the Walk-in Centre were expanded:

*Respondent: We're giving them a very comprehensive, holistic physical assessment, providing them with medications if necessary and also making sure that their other issues are being addressed. Have you stopped smoking? Oh you haven't stopped smoking, do you want to quit? ... I think they get a good deal... I think it's a fabulous service and I think, within our scope, I think they get good quality care from the team. So I suppose the only thing you could do to improve it would be to expand our role, make more procedures available, expand the medicines. I know it's very politically difficult because then we're stepping on the toes of the GPs.*

*Respondent: We're limited obviously, because of our protocols. I think the quality that we give is awesome. All the nurses here, everyone does absolutely fantastic quality care ... so the quality of assessment that we give is fantastic. But then the limitations that go along, if we could progress what we could do it would be awesome.*

*Respondent: I think it... the feedback from the patients is that we take more time, because we have more time, and we have the luxury of being paid by the hour not by the patient so you know, it's not altogether the doctors' fault, we have time to talk to them and to teach and to educate and that sort of thing and people appreciate that. So whether you can measure that in cost effectiveness terms I don't know. But I think it's valuable, I do think it's valuable.*

### **Relationships with patients**

Relationships with patients were regarded positively by nursing staff:

*Respondent: I really enjoy my interactions with my patients... All positive. Even the ones that have less than optimal outcomes, you know they don't get better or whatever, they still say, "you know what? Thank you". I had a situation which could have been viewed as negative for the patient, that the interaction was so good that they, despite having a bad outcome they still came in and said, "thank you so much and if you wouldn't have talked to me about the warning signs of this I would have never known and I would have had big problems".*

*Respondent: Personally, from what I see from consultations, I see the majority of my clients are very satisfied; feel that they have been thoroughly assessed even if I'd had to refer them elsewhere. They've indicated to me that they feel they have a good understanding about the justification I've made to send them to their GP or send them to ED or treat them*

### **Extra-personal factors**

#### **Clinical Decision Support Software (CDSS)**

The level of autonomy the nurses' experience and the capacity to deliver quality nursing care is influenced and mediated through the use of Clinical Decision Support Software (CDSS). Whilst some participants acknowledged benefits associated with the CDSS, most identified significant difficulties:

*Respondent: I think I have to admit that it's probably supportive ... I think eventually it will be great. But I just think we still need to keep chipping away and refining it.*

*Respondent: Yes, like a safety net ... very cautious, but I can see their point, because it's the first one, they don't know how much we can do so they make it very, very safe ... hopefully over time that they will be more relaxed knowing that we can do it and safely do it, they can be a bit more relaxed.*

*Respondent: It increases my consult times by 40 to 50 percent because of trying to navigate through the software and because I'm trying to find ways to navigate through the grey areas so the patient can get the best possible care ... We're forced to go through every aspect of the patient's life before I will initiate something as simple as a hangnail [laughs] you know...*

*Respondent: ... it's nearly like well the Walk-in Centre's going through the computer system as opposed to the computer system's made for the Walk-in Centre.*

*Respondent : The computer system. It's lengthy, very, very lengthy. I could honestly see, a lot of these... don't get me wrong I don't want to rush people*

*through, but a lot of these simple cough/colds or these simple splinter removals or some of these very simple stuff that we're set up for that take us ten minutes to do, write a quick note and we're done, take us 20 minutes to half an hour because of the computer system. So it, that is a massive challenge and yes some of us get really quick at it, but others are not so quick, are not computer savvy, so it takes a long time.*

One participant stated a belief that protocols were developed to appease stakeholders as opposed to being based on evidence-based practice:

*Respondent: I find that a lot of the protocols that we're realising here are kind of like are based on what traditionally the, what other people have done, not necessarily what's evidence based practice so in other words... we were forced to use Acticoat which is a silver dressing product on burn wounds which if you've ever used that it's a very awkward product to be using first of all, and it's extremely expensive, it's like \$15 a sheet and it's not appropriate for ... wounds but because the plastic surgery team uses Acticoat we had to use Acticoat instead of using a better product and so a lot of things we do are done because that's that they do and we don't want to piss them off and you know we don't want to step on anybody's toes.*

A source of frustration was the process, or at times, perceived lack of process involved in amending the protocols to make them more effective for patient care:

*Interviewer: So how does it go if you say we could really improve this protocol and this is the way we'd like it changed...?*

*Respondent : Write it up, put it together, ... present it to [ADON's name], [CNC's name], get them to have a look through it, yep, they're pretty good, they're usually... and then go to the Advisory Committee and then the Advisory Committee mulls over it and, something like the computer system would then have to go to Medibank Private to see if they can even do it within the system and then it usually gets lost through the trail and we don't hear anything about anything that's happening.*

## **Training**

All participants strongly expressed their belief that the preparatory training for their role in the Walk-in Centre could have been better:

*Respondent: I didn't feel it was specific enough ... I think all of us, we were all at the most senior most top of the nursing and we're thirsty for knowledge. But it was given at such a basic level I think the only thing of any benefit was our OSCIs.*

*Respondent: ...it would have been a lot better if it had been much more clinically based.*

*Respondent: I think being completely honest, we had ten weeks of training and I think probably eight weeks of that was not useful.*

*Respondent: Touched on information. I sort of felt that it needed to go a lot more in-depth. I felt that there needed to be quite a bit more clinical placement time for people to actually appropriately get assessed on each task and skill.*

This belief extended to a perceived gap in training for new employees, whose training is largely comprised of informal supernumerary arrangements with existing staff in the centre as opposed to participating in a formal training program:

*Respondent: Well it's, I haven't had actually any feedback on how I'm going but the biggest hurdle I suppose was the OSCIs which is the assessment criteria. Because I had no formal lectures or anything I, and I'm not saying like the rest of*

*them, but I did not have any formal lectures so there was no opportunity for me to pull out of, what's the word I'm looking for, the specific things that they wanted us to know, it's just been a hit and miss and as I said I've had no feedback, I don't know how I'm going, whether there's, of course there's areas, there's always areas for improvement but nothing's been highlighted to me about what I need to concentrate on. I mean I do reflection as most of us do I would think, as a patients goes off, oh I should have done this I should have done that.*

The absence of suitable training was identified as a possible reason for the absence of relief staff in the centre:

*Respondent: my biggest issue is there's no clear-cut training guidelines for new staff...*

### **Education**

A number of participants expressed frustration with the difficulty in accessing study leave due to the absence of relief staff, and at times the availability of education in-services that were not appropriate to their clinical needs:

*Respondent: One of the biggest mistakes that was made with this clinic was that ... there has been no allocated staff development time; it's all on your own at home... it would be helpful if they would actually allocate time during work hours*

*Respondent: I did actually say months ago we should have professional development by now. We haven't had any; we've just got the forms now so it's taken a year.*

At the same time most were also willing to pursue opportunities for professional development in their own time:

*Respondent: I think if you feel strongly about learning about something then you have to make the initiative. People shouldn't be spoon feeding you and especially at this level with RNs that we have in this department, if they can't go out and be proactive on getting on to, then I think well you know, 'cos the time's gone for worrying about somebody coming in and offering you this. If you want it go and get it.*

*Respondent: Like there wasn't any eyes ... arrange[d] it in my own time so the Registrar, so didn't expect any of us to be there but she was very nice and took me through.....but ... [ADON] she said you can book yourself in your own time so I booked myself in for an afternoon.*

Thus whilst nurses accepted that some study should take place in their own time, that there was some learning to be undertaken from peers within the clinic, they also felt that utilising the expertise of medical staff from areas external to the Walk-in Centre would be valuable for their professional development.

### **Relief Staff**

The absence of relief staff, and subsequent reduced access to opportunities for professional development and leave, was identified by all participants as a source of stress:

*Respondent: You can, you can put in for it [study leave], but it very much depends on staff numbers. I've had a couple rejected 'cos of the staffing levels.*

They described an ongoing pressure to attend work, even when unwell:

*Respondent: there isn't enough backup staff, that's a problem ... And we get guilty into coming back and I called for a carer's day and I got an email and I*

got a phone call can you come in when you put your kids to bed, that kind of stuff. And I was sick with pneumonia ...

### **Workload**

Whilst some participants referred to busy periods, overall this was not of concern and nurses felt they had adequate time to spend with patients and that their workload was very manageable.

*Respondent: Easy, this is the easiest job I've ever had. Honestly I put in a hell a lot of hours, because I enjoy what I do ... I don't mind it but this is an easy job. I don't know many places where you can see as little as, there's some people that see no more than six to seven patients a day which is problematic. I can see as many as 17 patients a day.....But you know, prior places I've worked ... your productivity is highly scrutinised and if you're not getting the numbers then you have to push them up faster. So for me I really enjoy the fact that, this job to me is cake in many respects...*

*Respondent: It's certainly picked up recently and when that's clock ticking I find it quite, there's pressure to move faster. But I never claim to be a computer whiz and I know I'm not the fastest typer...*

*Respondent: The workload is OK except that on Mondays which is our busiest day, often times if someone's off sick there's not enough replacement of staff.*

*Respondent: It doesn't bother me at all...In fact I could be busier.*

### **Resource allocation**

Participants were satisfied with the availability of physical resources; in fact some cited times when they believed money was wasted or spent inappropriately:

*Respondent: as far as the physical place, beautiful rooms, huge rooms, you know we're getting things that we don't need in this clinic because we have so much money coming in from various donations and things like that... Buying an urinalysis machine is completely inappropriate when you can just do it with a strip and compare it to a thing on a bottle or a chart on a bottle. I think that thing cost like 600... it cost a lot of money.*

### **Feedback**

A number of participants expressed a desire for feedback regarding the care they provide. Due to the episodic nature of conditions people present with at the Walk-in Centre, this often did not occur in the form of follow-up appointments or feed-back from other health care providers. Feedback was considered important in terms of both a source of education as well as reassurance in transition to the autonomous nursing role:

*Respondent: Well I would love to be able to follow up on what we do for the patients because I guess you ask about stress, about the work, that is one of the frustrations, is that we provide patient care but there's absolutely no feedback or follow-up as to what the outcomes were. So one could be doing the same thing over and over again but possibly not been on track so GPs will always have a follow-up consult or something like that if the patient hadn't, if the symptoms hadn't resolved but, yes I guess it would really be great if we had some sort of feedback on the outcomes of our treatment or outcomes on our clinical impressions. You know if we were spot on, we're not getting that feedback at all.*

*Respondent: Yeah it's been good. I do, 'cause I mostly work evenings if a patient goes up to CALMS I say on your way back down can you pop in and let me know what the doc said, and people are more than happy to, and they do.*



Some stated that opportunities for case management review would provide a good opportunity for feedback.

### **Implementation of nurse practitioner positions**

Role ambiguity related to nurse practitioner positions in the Walk-in Centre was expressed by nurse practitioners and prospective nurse practitioners, some of whom had been given temporary contracts while they completed their studies. One of these graduated as a nurse practitioner and stated that she was neither offered a permanent position as an advanced practice nurse, nor the prospect of a nurse practitioner position; she stated that this uncertainty resulted in her resignation from ACT Health.

*Respondent: She ... said I don't even see the nurse practitioner happening in the Walk-in Centre ... the pharmacy doesn't see it happening and he thinks it's going to be a good five years until the nurse practitioner role in the Walk-in Centre.*

*Respondent: ... I never worked as a nurse practitioner. My CPGs were not approved, they hadn't even been submitted. There's a requirement under the ACT framework that those are submitted and approved within three months ... We weren't supported and given the time to do them*

*Respondent: The other thing was that was frustrating was that they kept on delaying, unofficially delaying the CPGs development...*

This participant referred to discussion with Walk-in Centre management and ACT Health executive staff, which expedited activity regarding the implementation of nurse practitioner positions:

*Respondent: and basically from that conversation things were starting to move as far as getting the CPGs done, making sure that they would provide some sort of acceptable practice for nurse practitioners that would draw people in. Technically it was just basically, it was a realisation that things were not being progressed for nurse practitioners ... They finally kicked things into gear.*

### **Availability of a career structure and organisational mobility**

One respondent soon to complete their Master in Nurse Practitioner studies was asked about their future in the Walk-in Centre. They expressed uncertainty in regard to this:

*Respondent: ... so I don't know the future in here. But I don't know much about it from them. So one has left, one is still here and the other one has just graduated but there is no position for her so she has left.*

*Respondent: my understanding when this centre was started and from talking, everyone's understanding, was that there was a role for the nurse practitioner, it was already organised, it was already sorted out what was going to happen, and this is what the nurse practitioner was going to do, this is what the advanced practice nurses were going to do, and that hasn't come to fruition and I don't know, what are the plans for the nurse practitioner in the centre? And it's very difficult to get answers from anybody what is going to happen once they have their Clinical Practice Guidelines.*

*Respondent: I work full-time but I've only been, was given a temporary contract which has been renewed for another year. I was told that when I qualified I'd be given an option to apply for a nurse practitioner post but that has been very muddled. That's why we've lost one of our staff members so I'm not sure, I'm told that there could be a possibility but it's all very vague so it's a bit unsettling.*

## Intra-personal factors

### *Education and experience*

There was great variety in both levels of experience and education of the nursing staff. Of the participants all but three had tertiary level post-basic nursing qualifications. Three participants were currently studying towards graduate degrees and one towards a certificate qualification. Further details regarding the staff will not be provided due to the ease of identifying individuals in this small group.

### *Nursing role in the Walk-in Centre*

Perceptions of the role were varied, with most participants expressing general satisfaction:

*Respondent: ... I love the job. I love the patients. I love what I see. Yeah this is what I love doing and all my training and all my background, this is perfect for me, what is here, I feel. Now that I'm over the whole being autonomous I love it, I love it.*

*Respondent: The actual autonomy, seeing the patients, working things up. I look up stuff all the time just to make sure that I'm keeping up to date but no I love it. The actual job itself I love.*

However, there was some confusion about what the nursing role at the Walk-in Centre was intended to include:

*Respondent: I just thought there'd be a bit more chance for some primary health care and community stuff so probably I didn't really understand the role entirely when I took it on.*

*Respondent: ...the big difference that I think I couldn't quite put my finger on before is the difference between seeing one patient after another and them leaving after the consultation and it's a much more cognitive process and it's much less of a caring process and that has felt a bit strange in some ways.*

*Respondent: Well the autonomy I'm used to because I've worked in an autonomous role for many years. It is different in that my perception of primary health care is, using a clichéd word, holistic and this is definitely just episodic care. A patient comes in, we see them, there's a bit of primary health care I guess because we try and fit in the health education so it isn't what I thought it would be but at the same time we are allowed autonomous practice which is wonderful yes.*

## DISCUSSION

### *New challenges to the nursing role: autonomy*

The autonomous nature of the nursing role in the Walk-in Centre is different to traditional nursing roles. Nurse practitioners have been defined by their autonomy; however autonomy for the advanced practice nurses in the Walk-in Centre is novel. This aspect of the role was described by all but one advanced practice nurse, as a significant challenge in the beginning, which they have now adapted to and express great satisfaction with. This satisfaction is in keeping with research, which indicates that a major determinant of nurse job satisfaction is decision autonomy.<sup>37-40</sup> Nurses who prefer autonomous decision making have been found to be “more satisfied than those nurses with little or no preference for it”.<sup>39</sup> Hence nurses who choose to work at the Walk-in Centre experience increased levels of job satisfaction purely associated with the autonomous nature of the work.

Kramer and Schalemborg (2008) state, “Autonomous practice includes both types of decision making—independent and interdependent”<sup>41</sup> Interdependent decision making refers to that made in consultation and collaboration with other health care professionals.

The Walk-in Centre advanced practice nurses have opportunity for collaboration and interdependent autonomy, through the presence of nurse practitioners. However, this is not available on every shift. Nurse practitioners have no opportunity for interdependent autonomy, which will be discussed in the next section.

### Implementation of the nurse practitioner role in the Walk-in Centre

Availability of a career structure is strongly linked to the ambiguity of the nurse practitioner role and perceived lack of organisational support for development and implementation of this role in the Walk-in Centre. Three nurse practitioners have been employed at the Walk-in Centre; two with permanent contracts and one on casual contract. One permanent nurse practitioner had resigned at the time of data collection. A third staff member gained a nurse practitioner qualification whilst working as an advanced practice nurse; however resigned due to ambiguity and uncertainty regarding a future nurse practitioner role or a permanent position at the centre.

The nurse practitioners expressed a desire for a source of medical consultation and mentorship within the Walk-in Centre. The business case approved for the nurse practitioner positions in the Walk-in Centre<sup>42</sup> includes a position description, which states that Walk-in Centre nurse practitioners are operationally responsible to the Medical Director of Hospital in The Home, The Canberra Hospital. This arrangement was not implemented with the opening of the Walk-in Centre, resulting in an absence of a source of endorsement by senior clinical staff or an ongoing source of collaboration and advice for the nurse practitioners. In the absence of this, the Walk-in Centre nurse practitioners have no opportunity for collaboration and consultation with medical practitioners, who are the only source of interdependent autonomy for them. Nurse practitioners do not work in isolation; collaboration is integral to their role.<sup>43</sup> This isolation has significantly undermined the nurse practitioner role in the Walk-in Centre.

It is noted that an arrangement was put in place in early 2011 for the Walk-in Centre's remaining permanent nurse practitioner to have the opportunity to contact The Canberra Hospital's GP liaison officer, who works two days per week.

Delays in approval of clinical protocols limit nurse practitioner practice.<sup>44</sup> The data indicate that the management of the Walk-in Centre has not endorsed the role; in fact the nurse practitioners' perceive that they are unsupported in the development of clinical practice guidelines. *Nurse Practitioners in the ACT: The Framework*<sup>45</sup> requires that clinical practice guidelines are submitted to ACT Health within three months of a nurse practitioner's commencement in a position. At the time of this report, the Walk-in Centre nurse practitioner has completed the clinical practice guidelines and is waiting for the signed endorsement of members of the Clinical Practice Guideline Advisory Group.

The frustration reported by nurse practitioners in terms of their inability to work to their full capacity is referred to by Handy(1993)<sup>34</sup> as the relationship between expectations placed upon individuals and their own perception of role and competence. The role and expectations of the nurse practitioner is both occupationally and legally defined.<sup>46,47</sup> In the case of the Walk-in Centre, nurse practitioner role ambiguity has led to both role incompatibility and 'role stress'.<sup>34</sup>

### Relationships with other healthcare providers

Whilst at times the nurses expressed dissatisfaction with their relationships with emergency department doctors, this issue was seen to resolve with time and was often due to mutual frustration with the requirement for the nurses to adhere to protocols.

This was similar to the United Kingdom experience, where attitudes of other local health professionals (particularly general practitioners) were perceived as being the most important potential barrier to the success of Walk-in Centres; although most staff felt that these



relationships were improving with time.<sup>48</sup> Whilst the relationship with general practitioners is limited, the nurses are satisfied in regard to this.

### New challenges to the nursing role: Clinical Decision Support Software

The use of CDSS is specifically aimed to both mediate and support the new autonomous role. Whilst the nurses acknowledge some benefits associated with using the CDSS, it is a source of frustration in terms of having time to develop and change protocols and the time it takes for these changes to be approved by the Walk-in Centre Clinical Advisory Group. Additionally, their capacity to deliver high quality, timely nursing care is perceived to be hampered by the onerous nature of the CDSS. These findings are similar those of Salisbury et al (2002),<sup>3</sup> who highlighted difficulties encountered by Walk-in Centre nurses using CDSS. They recommended caution when implementing CDSS, which should be considered “highly experimental and subject to careful planning and on-going evaluation”.<sup>3</sup>

### Provision of quality nursing care

Gray-Toft and Anderson (1981) reported that nurses were most stressed when their ability to practice quality nursing care was impeded.<sup>49</sup> The staff are highly satisfied with the quality of care they are able to provide in the Walk-in Centre. Their responses at interview indicate a united and cohesive nursing team; happy with relationships with patients and the time available to deliver care. These two factors (delivery of quality nursing care and relationships with other nursing staff) were found by Dunn et al (2005) to be the first and second most important factors in increasing nurse job satisfaction.<sup>50</sup> These factors might be associated with the retention of advanced practice nurses in the Walk-in Centre to date.

Enablement of the nursing staff's belief that the Walk-in Centre could provide an improved service through increasing the scope of practice is a factor which they perceive would further increase their satisfaction in regard to the capacity to provide quality nursing care.

### Training and education

Meeting the training needs of nurses with diverse education and experience was found to be a significant challenge for managers of Walk-in Centres in the United Kingdom.<sup>32,48</sup> This is an issue that needs in the first instance to be addressed by ACT Health and, in time, to be addressed through inter-sectoral collaboration to ensure that undergraduate and post-graduate nursing courses in Australia are “keeping pace with reform agendas that promote expanded roles for nurses in primary health care, prevention and health promotion”.<sup>51:211</sup>

A lack of opportunity to access ongoing professional development and education is also related to a lack of relief staff to enable the release of existing staff for these purposes. This might be due to issues regarding initial training and induction of relief staff, which needs to be further explored.

Linked to dissatisfaction with opportunities for education is access to feedback regarding clinical performance. This was also experienced by Walk-in Centre nurses in the United Kingdom.<sup>32</sup> Feedback is perceived by nurses as an opportunity for learning, as well as a source of reassurance within the new autonomous nursing role. Opportunities for feedback, whether through case management review or direct patient feedback mechanisms would provide a source of satisfaction addressing inter-personal and extra-personal factors.

### Input into the operation of the Walk-in Centre

The presence of nursing staff on the Walk-in Centre Clinical Advisory Group and the Management Group implies a bottom-up approach to implementation and management,<sup>52</sup> providing avenues for staff to have ongoing input into the operation of the centre. Despite this approach aimed at engaging and empowering staff, this is not their perception. This perception was reflected in their responses to the IWS survey, which indicate dissatisfaction with the level of opportunity to participate in administrative decision-making processes or planning for policies and procedures. Examination and intervention to close this perceived

gap between management and the nursing staff could provide a source of increased nursing satisfaction in the future.

### Organisational flexibility and mobility

The ambiguity regarding nurse practitioner roles clouds perceptions of flexibility and mobility for the advanced practice nurses in terms of their capacity for advancement to future nurse practitioner roles in the Walk-in Centre. "Nurses who have few opportunities for advancement are less likely to be committed to their job".<sup>53</sup> The advanced practice nurses with ambitions to become nurse practitioners in the future expressed uncertainty regarding their future at the Walk-in Centre due to this role ambiguity; a potential source of future staff attrition.

A clear understanding of the nurse practitioner role in the Walk-in Centre, the associated clinical governance and need for collaboration will support successful implementation; providing a source of satisfaction for nurse practitioners able to fully implement their roles, and for advanced practice nurses in terms of an available career structure and organisational mobility.

## CONCLUSION

When higher levels of nurse job satisfaction are experienced, there is an increase in morale and commitment which makes it more likely that a nurse will stay in the profession.<sup>28</sup> Nursing job satisfaction is important to both health care providers and patients. Nursing satisfaction has been linked to positive patient outcomes<sup>29,30</sup> and a greater perceived quality of care.<sup>31</sup>

There are a number of interfaces between the three domains of nurse satisfaction with working in the Walk-in Centre. Sources of dissatisfaction are reported mostly in relation to interpersonal factors. Barriers to access ongoing education and, for some, a perceived lack of ability to contribute to the running of the Walk-in Centre are sources of dissatisfaction. For current and prospective nurse practitioners there is a sense of role ambiguity and the absence of an available career structure or organisational mobility within the Walk-in Centre. Sources of satisfaction are present in all three domains and are expressed in relation to autonomy, the ability to provide quality nursing care, a manageable workload and relationships within the team. This finding is similar to previous research that has found that sources of perceived satisfaction and dissatisfaction are overlapping, but separate phenomena.<sup>26,50</sup>

# Chapter 6 Interviews with stakeholders

## INTRODUCTION

Within the evaluation framework, stakeholder satisfaction (with nursing staff satisfaction) is an indicator, or “unit of measurement”<sup>22</sup> of the efficiency of organisational structures and processes. This measures the capacity for these structures and processes to provide care to patients, families and communities;<sup>22</sup> that is, how these enable implementation and achievement of the overall objectives of the Walk-in Centre.

## AIM

The aim of this study is to gain insight into stakeholders’ perceptions of, and satisfaction with, the structures and processes in place at the ACT Health Walk-in Centre.

## DESIGN

As with every aspect of the evaluation, this study was designed within the adapted framework for performance assessment in primary health care.<sup>22</sup> Interview questions were developed under the subheadings identified within the ‘Organisational Structures and Processes’ aspect of this framework (Physical facilities and equipment; Human resources management; Information systems; Staffing; Service organisation and management; Processes of care provided; Inter-provider agency networks and relationships; Community networks and relationships; Performance assessment). Within these sub-headings details of questions were developed utilising Hollander et al’s framework (2010) in which key questions are determinant on the nature of the evaluation; proof of concept, implementation, process or outcome evaluation.<sup>54</sup> (See Appendix C. ACT Health Walk-in Centre Stakeholder Interview Questions)

The qualitative research methods employed were in-depth interviews and focus group discussions. The data obtained from these enabled a phenomenological study; concerned with the study of experience from the perspective of the individual, their lived experience, and subjective analysis of that experience.<sup>35</sup>

## METHODS

Ethics approval to interview the stakeholders of the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.11.028) on the 8th March 2011 and subsequently given expedited approval by The Australian National University Human Research Ethics Committee on the 16<sup>th</sup> March 2011 (protocol no. 2011/120).

### Recruitment

Stakeholders were purposively selected through the identification of individuals and organisations who had an expressed interest in the Walk-in Centre. Eleven stakeholders were members of the Walk-In Centre Clinical Advisory Group. This group was formed prior to the opening of the Walk-in Centre to provide a source of ongoing advice and discussion regarding the Walk-in Centre. The membership and terms of reference for this group are in Appendix J. In addition to this group, other stakeholders were identified through ACT Health documents, which identified stakeholders included in early consultation processes. Some potential participants were identified by the evaluation team at different times during the evaluation; these included emergency department nursing and medical staff and Walk-in Centre reception staff.

A total of twenty five (n=25) stakeholders were invited to participate in interviews to gauge stakeholder satisfaction with the Walk-in Centre. Information about the project and

participation was sent via email. Stakeholders who would like to participate in the project contacted the research team via email or telephone to arrange a time and date to participate.

### Data collection

Participation comprised a face-to-face interview. Stakeholders were required to sign a consent form prior to participating. Completion of the interview took place at various times and locations determined as convenient to participants, with consideration made for privacy.

Interviews were audio-recorded and transcribed verbatim. All identifying information about the participants was removed from the transcripts prior to analysis.

### Data analysis

Interviews were recorded and transcribed, and any identifying information about the participants removed. NVivo 8 software (QSR International Pty Ltd., Melbourne, Australia) was used to manage the data and facilitate coding. Transcripts were analysed using thematic analysis which focuses on identifying ideas, concepts and patterns within the data. These were analysed and applied within the themes identified during study design. An inductive approach was used for analysis similar to that described by Braun and Clarke,<sup>36</sup> which involved reading and re-reading the transcripts; assigning of codes to sections of the transcript to categorise the data into themes and ideas; and comparison of these themes for similarities, relationships and tensions.

### Data storage

## RESULTS

Fifteen (n=15) stakeholders agreed to participate in the study. Four of these (two groups of two people) requested to be interviewed in focus groups rather than at individual interviews. Results are reported within the sub-headings identified within the design of the study.

Stakeholders represented the following professional organisations:

- > ACT Health
  - ACT Health executive
  - Walk-in Centre management
  - Walk-in Centre Clinical Advisory Group
  - ED doctors and executive
  - ED triage nursing staff
  - ACT Health physiotherapy
  - ACT Health pharmacy
- > ACT Australian Medical Association and the ACT Division of General Practice (interviewed together)
- > Health Care Consumers' Association of the ACT

### Physical facilities and equipment

#### *Layout of the Walk-in Centre*

Eleven out of the fifteen participants had been to the Walk-in Centre; most describe the physical layout of the Walk-in Centre as satisfactory. They are satisfied with the amount of light and space in both the waiting area and the consultation rooms. One participant referred to a potential problem of an inadequate number of consultation rooms, if presenting numbers increase in the future.

Participants are satisfied with the quality and quantity of equipment and resources. In terms of occupational health and safety, one participant expressed uncertainty in regard to patient safety in the waiting room:

*Stakeholder: I was there one time when there was a mental health consumer who was not well and it provided the staff with safety and they handled it relatively well. I was concerned at some stage because I was there with a ten year old at the time waiting to see a nurse and I thought oh OK where do we go if things get violent? That's when I thought... I was a little unsure*

## Information systems

### *Clinical Decision Support Software (CDSS)*

The CDSS was identified as problematic for a number of reasons, including the inability for it to interface with other systems or to generate particular reports:

*Stakeholder: it is a standalone system, which we should never have standalone systems in A.C.T. in this day and age. It doesn't interface with our (indistinct word – 5:48) system, it doesn't interface with Clinical Portal Concerto, so you can't... if a patient comes into the Emergency Department 24 hours after they've been to the Walk-In Centre they cannot see the record of what's happened in the Walk-In Centre. And that should never have been, in my opinion, allowed to happen ...*

*Stakeholder: We have satellite software that's not integrated with other A.C.T. Health software programs, and as a consequence there are a number of work-arounds, and some duplicated effort. For example, double registration in one system, and a second system in parallel. And at the beginning of the client journey, and at the end of the client journey, it's a manual procedure to fax a summary to the GP. And then there's a manual process for scanning an episode summary into the patient information system.*

*Stakeholder: a lot of the information I was interested in wasn't easily extracted from the database ...What they were giving out and who they were giving it to and what percentage of patients that turn up with tonsillitis get antibiotics, that kind of thing. That's what I was interested in ... You couldn't get that from the database.*

*Stakeholder: And I think certainly from a software point of view for the Reception staff, and for the nursing staff, to have two systems that don't integrate is just ludicrous, and a nightmare, and so frustrating. So I think we need to be able to do something about that, to streamline that process.*

## Service organisation and management

### *Model of Care*

#### Scope of practice

Most stakeholders are satisfied with the nurse-led model of care; however most stakeholders also believe for the model to be successful, the scope of practice of the advanced care nurses needed to be extended and the nurse practitioners must be supported to fully implement their roles.

*Stakeholder: I think it's a safe model of care. I don't know if it uses the full scope of practice of registered nurses or advanced care nurses that are in practice, it certainly goes no way to fostering a culture of positive thought around nurse practitioners... I think it's a shame...*

*Stakeholder: I think it's got the capacity to expand further with the skills that they've got.*

*Stakeholder: I think it works, but it only works for that limited scope of practice ... and I think expanding that any broader than it is now or to make their decision making more independent, because at the moment it's very dependent on protocol. I think that will probably be a bigger step forward and I think that will be a bit of challenge for the advanced practice nurses. The nurse practitioners do have the skills, but there's a lot of issues that they're trying to get through to get their practice guidelines up and running.*

*Stakeholder: you could really increase the capacity of the clinic and what it can accept if you roll out a slightly different model.*

*Stakeholder: I'd love for them to be doing more. I think they've got the ability, they're just, well I understood to start with it was a new project so they couldn't take on too much and that's understandable, you don't want to take off more than you can bite to start with but they seem to have cut off their nose to spite their face now.*

*Stakeholder: So I know from a couple of different angles that people have found that a really valuable service, but I think I can also say there's frustration from clients that it doesn't quite fit the bill on all levels for people. I think certainly because the nurses can't prescribe they're limited in how they can treat certain conditions; the imaging part of it, so having to come back after a weekend for x-rays ... So I think we do need to look at how we can develop the scope of practice.*

*Stakeholder: And then there'll be a small group who will be frustrated that they couldn't do an injection, or they couldn't do something... something was out of their scope, and they think well you know, what are you here for anyway? What a waste of my time. So I'm sure that... and that I think that frustration would be with some of the nurses too, who know perfectly well what needs to happen, but can't do it because they're not autonomously allowed to make the decision.*

Two stakeholders believe that the nurse-led model of care is a 'silo' approach to health care, which is contrary to current and future projections for primary health care to have a multi-disciplinary approach.

### ***Nurse practitioners***

The role of nurse practitioners in the Walk-in Centre was raised by most stakeholders. It is acknowledged that this role has not been fully implemented in the Walk-in Centre, which has implications for the scope of practice of the Walk-in Centre itself and subsequently the successful implementation of this nurse-led model of care. Many stakeholders are aware of the frustration experienced by nurse practitioners employed in the Walk-in Centre due to their diminished capacity to fulfil their role:

*Stakeholder: I know they're very frustrated, and one has already left. I think it's a very difficult road for them, and there's no magic in this, and I can't foresee how it's going to play out.*

*Stakeholder: I think for the nurse practitioners, we only have one currently because one left to move one ... but the nurse practitioner we have is exceptional at what they do, and has the ability to work to a more evolved scope of practice than currently they can, and I think that's a frustration for that individual.*

*Stakeholder: my personal view is it's a lost opportunity having nurse practitioners work in such a tightly controlled environment and we need to be fostering that role so that there's career pathways.*



*Stakeholder: I guess I have a real worry that the nurse practitioner role will not progress in the Walk-in Centre and I think that will be a significant loss because I guess the nurse practitioner expertise is extremely valuable. Even at the moment the nurse practitioner working in the Walk-in Centre is not working as a nurse practitioner, but advanced practice nurse. The expertise he brings to the group is invaluable and I think if that is lost, it'll mean that the overall care will suffer. I don't know what the answer is?*

Two stakeholders were uncertain as to the requirement for nurse practitioners in the Walk-in Centre model of care.

### *Alternative models of care*

Whilst the current nursing model of care has not been fully realised, a number of stakeholders believe the model of care could be enhanced with the inclusion of a doctor. The model would still be nurse-led, with the doctor's presence providing a source of collaboration, mentorship and referral for patients who fall outside of the scope of nursing practice. Some stakeholders envision a future where one doctor provides this support across a number of Walk-in Centres:

*Stakeholder: nurse led, if you think about it, it's not nurses giving all of the care, but it's led, the care is led or initiated by the nurse and I think that's what people have to try and get their heads around, because it's not just about a nurse providing the care, it's about leading that care and there are good referral processes that come about as a result of that nurse led care, and that's the key I think.*

*Stakeholder: ... the presence of a GP in the centre might enable treatment of people at the Walk-in Centre who fall outside of the scope of the nurses but are not appropriate for ED.*

*Stakeholder: I think perhaps the option for them to keep that idea that it's a nurse led clinic would be to have the nurses assess the patients and then to bounce off a doctor, as opposed to a doctor taking in a patient and saying to the nurse can you, so the nurses are still assessing patients and treating them accordingly but they've got that buffer. Or if that patient, or there's one patient that's a little bit grey in terms of which pathway to take they can say to the doctor can you finish this.*

*Stakeholder: ... there would be a GP within the clinic to... that would have been a model that provided much more flow of patient, greater numbers of patients being able to be seen, and would have changed the depth of the patient that could have been seen...and I would have thought the ratios would have been five nurses/nurse practitioners to one GP. I think that interestingly from discussions with the nurses, I thought that perhaps they wouldn't want to have a medical practitioner within the clinic, and that they really wanted to be a nurse only led clinic. But in actual fact I think that they would value having a Medical Practitioner there, and I think that works well....*

Two stakeholders refer to the possibility of including physiotherapists in the Walk-in Centre model of care.

One stakeholder is adamant in the belief that the Walk-in Centre model of care, with its aim to treat episodic minor injury and injury is not a model of care which will address the need for access to primary health care currently required in the ACT:

*Stakeholder: I don't believe that the Walk-in Centre is the correct model in terms of patient care and I certainly don't believe it's the correct model in terms of value for money.*

## Human resource management

### Staffing

#### Staff education and training

There is general concern with the provision of training and ongoing education for Walk-in Centre staff. In particular, stakeholders involved in the initial training for Walk-in Centre staff voiced concern in regard to the provision of training for new staff, which at this point in time, some perceive to be non-existent:

*Stakeholder: one of the concerns I do have, we did very intense training on medicines with the new staff before the centre opened, but my concern is what's going to happen to the new staff that are now recruited with that training.*

The need for ongoing professional development was identified, in particular for nurse practitioners:

*Stakeholder: These are expert senior nurses, and they're very hungry for continuous improvement, and whilst they're delivering a service, it's very hard for them to have quarantine time. And as well, they're now in a model of care that's autonomous, and so there aren't people in the workplace who know more than them, to give them real time feedback, and that has been expressed as an area for improvement, or development.*

*Stakeholder: I don't know what they're getting as far as ongoing education, professional development, any of that. Clearly if that's going to come, given that they're working at a level of nursing practice that doesn't otherwise exist in the ACT, it really needs to be coming from either a GP or from us. I don't know if they're having any. If it is and it's nurse driven I'm not sure if that's completely appropriate because they are working at a degree of independent practice level that doesn't otherwise exist.*

#### Skill mix in the Walk-in Centre

Despite having the same induction training to work in the Walk-in Centre, skill-mix was referred to by a number of stakeholders as a factor influencing quality of care. This referred to the large variance in education and experience evident amongst the staff, resulting in similar variance in scope of practice and subsequent care provided, from one nurse to another:

*Stakeholder: The care provided I think, obviously depends if patients fall within their scope of practice and I do think there's probably quite a lot of variability on which nurse you get. I think overall they do a really good job and there's a lot of satisfied patients that get care through there.*

*Stakeholder: Are some nurses more competent or more expert? Yes. And will you get a better service from an expert nurse in that field? Yes, probably you will. But is the less experienced nurse adequate? Yes. Safe, they do a good job, and they might redirect you to a GP, so the outcome is safe and adequate.*

*Stakeholder: The advanced practice nurses all went through the same training, but some are a little bit more evolved than others because they had a bigger sort of clinical background prior to coming into that position.*

## Processes of care provided (PHC)

### Protocols

The use of protocols as integral to the model of care is identified as problematic to most stakeholders. A number of issues were raised, central to these was the fact that the



protocols do not enable the nurses to utilise their clinical decision making skills when assessing and treating patients.

*Stakeholder: You know in a funny way they were recruited to be more independent and paid to be more independent but in many ways, and at least one of them have come back to us because they felt in fact they were less independent because they were more constrained by the protocols ...*

*Stakeholder: I would probably argue that because of safety and the protocols, and the way things have been set up, that more time is spent with patients than necessarily is required for the minor complaint that they've come for. It provides a wonderful, safe sort of care episode for the patient. I don't know how sustainable it is that nurses will have that much time to provide that, but I think patients love it. I think with evolution those protocols will be changed, in as much as there will be greater autonomy, greater decision making ability.*

One stakeholder believed that protocols support nursing staff, but might be prohibitive of practice. This stakeholder supported the use of guidelines and standard operating procedures in collaboration with the clinical decision-making capacity of nurses, a view supported by a number of others:

*Stakeholder: Well, I understand why they're there, I think that they do limit the practice of experienced nurses and it's very interesting because one of the things that hits home to me was the rejection... early days mind you, but the rejection of a patient who came in to have sutures removed because there was no protocol for removing sutures, and yet removing sutures is part and parcel of the role and function of any registered nurse. So, you know, I think that the processes sometimes can be too processed and there needs to be an understanding that there are nurses practicing in there within a scope of practice as well as a protocol, so there needs to be a good blend of both.*

*Stakeholder: Corporate risk management strategy, yes. Media risk management strategy, yes. Stakeholder risk management strategy, yes. The AMA and the doctors love them. General practice liaison, GP liaison, yeah they're very supportive. Would the care be less safe if they all just had a developed scope of practice? Don't know, I don't know. But if you think about a nurse, a registered nurse on a board, do they work in the same way to treatment protocols? They've got a scope of practice, there's competencies. Is it always as prescriptive as to how they must deal with a particular situation? What sort of flexibility do they have to make decisions based on their understanding of the situation? ... If the medicos were a bit more supportive of it maybe we could actually have a more flexible system.*

One stakeholder praised the way in which the nurses had adapted their consultations to the protocols; retaining the capacity to engage and converse with patients:

*Stakeholder: The way I saw it used at the Walk-in Centre was great because they used it as a guide but they didn't let it get in the way of the conversation ... So even though they have this incredibly prescriptive tool, that the medicos love, that the rest of us struggle with understanding why it needs to be so prescriptive; even though they've got that tool they're able to engage and use that tool positively.*

## **Referrals**

A significant source of dissatisfaction for emergency department staff is related to referring a patient to the Walk-in Centre and that patient subsequently being redirected back to the emergency department, often referred to as double-handling:

*Stakeholder: So you risk it and you think yeah that might work and you refer them, because the person clearly wants to get on with it so you say look this is the situation, this is what I'm going to do. Sometimes you even triage them and process them here and say look this is the situation, this is what's going to happen if you stay here, my suggestion to you is why don't you go down to the Walk-in Centre and see how you go because you'll get seen a lot quicker. But 90 per cent of the time they come back.*

*Stakeholder: I find that's tricky for the patients as well because if they've been at WiC and they've either been brought up or walked up themselves, if they haven't got pressing issues like chest pain or breathing problems which would necessitate them being seen faster they still then get triaged accordingly so they might be told I've got a few other sickies to see in front of you, which is the same as if they were waiting at the front, in their mind they've already been seen and they've got to go back to the end of the queue again, wait to get the triaging done, and then you get the clerical done and then they're back in the waiting room waiting, waiting, waiting. So they're journey is extended, and especially if they've already been to us and we've said here's an option, you could try the WiC, they've gone down and then come back up again.*

*Stakeholder: ... so if someone comes in and needs to be referred on, either at the very beginning of the process after they've been seen initially or at the end of the process when it's realised that whatever the problem is has to be referred on there is that perception perhaps of duplication.*

An additional source of frustration is overall referral of patients to the emergency department, which stakeholders state has eased over time:

*Stakeholder: we were very frustrated in the initial few weeks and there was always going to be some teething problems that there were many patients being sent to us because that was what the protocols said, who were clearly appropriate to go back to see a GP within 48 hours for example rather than go to an Emergency Department to see someone there. But I haven't had those issues anywhere near as much lately.*

Some stakeholders would like improved and expanded referral systems in place at the Walk-in Centre:

*Stakeholder: Would like to see more, an improvement in the way that they can be referred, you know referral to fracture clinics, referred to sexual health clinics; so that internal referral within the health system.*

*Stakeholder: I'm not sure if Walk-in Centre staff are able to refer patients to providers such as community health for wound dressings, but I believe this would enhance access, provision and continuity of primary care services.*

## **X-rays**

The Walk-in Centre's limited access to Medical Imaging services (during business hours) is a source of dissatisfaction for a number of stakeholders:

*Stakeholder: But they're also a little bit limited, from a patient point of view and convenience, for example someone that needs an x-ray they can only do an x-ray at that time in business hours using the outpatients so from a patient point of view that can be a real pain*

*Stakeholder: I think it was felt that if it was a safe injury, and something the Walk-In Centre could treat, then it would be safe to put in interim management of the injury, and then image it next business day. If it wasn't, then the patient probably shouldn't be in the Walk-In Centre anyway, and should present to the Emergency Department, and then would be imaged appropriately. I know from a*

*patient point of view that's not great. I wouldn't like to have to go twice. So I don't know whether that's something that we will be able to change over time. I'd like to think it is something that we could change over time, but there will be... there would have to be a lot of consultation with the Medical Imaging Department around that.*

However, providing increased access to X-ray services for the Walk-in Centre is seen by some to result in decreased access for other services within The Canberra Hospital:

*Interviewer: So I wonder if they're going to be able to increase their access to X-rays.*

*Stakeholder: Who knows? I guess after hours stuff they have to either come to us or the main imaging department. Pros and cons for everything because then that slows our turnaround.*

### Quality of care

Most stakeholders' comments regarding quality of care were anecdotal:

*Stakeholder: And I think that really the feedback anecdotally from people in the community is how impressed they've been with the service that they've received.*

*Stakeholder: I believe that, in terms of the care they get, it's really good care, within their scope of practice. Their waiting times are a lot better than ours in terms of less waiting time. And people who've had contact with, successful contact as in they haven't needed to come up to us other than perhaps to say we've been down there and everything's sorted, that's the only kind of feedback we've been getting, have been impressed with the care they've received.*

There was some concern voiced by two stakeholders that patients were being referred to their GPs when they should have had immediate attention from the emergency department. There was also some concern voiced by the same stakeholders that the quality of written communication with the patient's usual GP could be improved.

One stakeholder had attended the Walk-in Centre three times with family members:

*Stakeholder: In terms of the treatment I thought it was incredibly thorough ... they went and got another one of the advanced practice nurses who had some experience of eyes and ears from the UK and so they knew, and I was pleased because it meant that as a team they understood each others' specialisation, who was on board, who was available and who they could bring in. So it was comforting to know that they were using each other's expertise that they were looking at the whole picture...*

Those with professional experience of patients attending the Walk-in Centre have positive feedback:

*Stakeholder: And I think they have good assessment skills. There've been a couple of very good pickups where they've picked up really sick patients. The majority of patients they refer up to us aren't particularly sick and its sometimes protocol based, it's sometimes based on just their insight and experience and you get calls when it's not necessarily a protocol that says refer it's the senior person that's worried about someone and that's totally fine and there've been a couple of really sick patients that they've appropriately picked and I'm not aware of any major incidents that they saw and sent home or anything like that and that's all great and that's what we want it to be. From a safety point of view I don't think that's a problem.*

*Stakeholder: I have to say the patients of mine who've used the service have spoken with great regard.*

## Cost of Care

Whilst quality of care is considered high, the cost of this care is flagged as an issue to be considered:

*Stakeholder: The quality of care, I think, is very good. But it comes at a cost and the cost is in relation to staff, the hours of operation and the fact that for all intents and purpose it's a free service to the client. So, the quality is good, but it does come at a cost.*

There was concern amongst two stakeholders that the funds allocated to promoting the Centre was too high and could have been better utilised elsewhere in the ACT primary health care system. As noted earlier, there was also a view that the nurse led model of care was a siloed approach and that funding for the employment of primary care nurses to work in ACT general practices could have been an alternative strategy for improving access to primary care services.

## Access to Primary Care

### *Location of the Walk-in Centre*

A number of stakeholders, whilst supportive of the model of care, with potential changes to enable increased scope of practice for the nurses, are not supportive of its current location at The Canberra Hospital. They are outspoken in their belief that the location of the Walk-in Centre brings people requiring primary care services to a tertiary care campus and often results in these people seeking care in the emergency department, when they would otherwise have not sought treatment there:

*Stakeholder: I think it needs to move off the campus. I don't think it's good for them to be based at the Canberra Hospital campus.*

*Stakeholder: It would be better placed away from a tertiary care site – a shopping centre, like Civic ... This would prevent people who are presenting with primary care problems from subsequently presenting to tertiary care sector, ED if they can't be treated at the 'Walk-in Centre'.*

Additional feedback regarding the location of the Walk-in Centre is that it needs to be placed in areas where there is an identified need for improved access to primary care services; where general practice services are known to be inadequate.

*Stakeholder: I think it would be a valuable resource if we clearly identify ... the demographics of who presents, throw that into the demographics of Canberra if you look at age groups, if you look at you know, find out how many of the patients that present actually do or don't have a GP recorded. Let's look at that. I think that data will give you a screaming, it'll actually plot on the map where the Walk-in Centre should be almost for you, based on those demographics. And I think, I would have always supported, and I think it was a worth a trial in that role and I would continue to think it's worth continuing to try in that role, whether it's a second one or whether it's moving of the current one that's a different question.*

One stakeholder discussed variation to the model of care, dependant on where it is located:

*Stakeholder: My personal opinion is it depends on the location and, I think, where it's currently located at The Canberra Hospital, it would function quite well with advance practice nurses. But if you were to place a clinic in the City and run it Monday to Friday during business hours then nurse practitioners would be the type of person you would want employed in that clinic.*



### *Has the Walk-in Centre improved access to primary care in the ACT?*

When asked if they believe the Walk-in Centre has improved access to primary care in the ACT most stakeholders believe that it has. Some answers were anecdotal, whilst some were informed of numbers presenting to the Walk-in Centre through their roles on the Clinical Advisory Group:

*Stakeholder: Yes, because I think it's provided another model of opportunity for patients to get to care. Yeah. And to get to care in what is really a very timely way.*

*Stakeholder: I would say if you've got something minor, if I had a cut finger, that's where I'd go. So I think... I would have to say yes. I haven't used the Centre, but I think that it's filled a gap. My GP is hard to get into, my personal experience, and so if I needed something in a hurry, then I would use the Walk-In Centre. So I would have to say yes.*

Whilst the perception is that access has improved, some stakeholders question if it has also created demand for services:

*Stakeholder: I've certainly heard lots of really positive things from friends and people I know that have attended and received a good primary contact service. I guess I do wonder whether what we've done is created a new population of patients that perhaps wouldn't attend somewhere else. You know I'm not quite sure how much is that they've been just offered a new point of care or these are new people who just wouldn't have gone somewhere previously.*

*Stakeholder: Yes, I do ... Because it's another point of access. It's another point of access. If you get, I don't know, 200 people a week going to a walk in centre, they're either 200 people a week who would have gone elsewhere or 200 people a week who wouldn't have sought any help and in terms of improving the health requirements, or the health needs of our community, nobody could argue that people sitting at home getting better without seeking help is necessarily the right thing to do. So, if the Walk in Centre saw no one and sat there empty, of course you'd say that it didn't improve access for people in the community, but the fact that it's seeing 200 people a week means that it must be doing something. And they are one off occasions of service so that's 200 different people every week, so you know; I think that it is making a difference. But again, how that evolves with any changes to the focus of a Walk in Centre will see that either improve or stay the same, or service a different need.*

Some believe the Walk-in Centre might have made a difference, but the cost of the difference needs to be considered:

*Stakeholder: I would say barely. I have no knowledge of the figures as to where the numbers in GPs in this area have gone down. I know ED numbers haven't gone down. You know access, health care demand is unlimited [laughs] and there's no question there are more people accessing primary care in and around this campus than there were 12 months ago. Whether that's because its more freely available and whether that's good bang for your buck when you consider how many people need primary care in say Gungahlin just to pick a suburb out of the air, where there's bugger all GP services. That's a decision that needs to be made in the light of what its cost and what you're doing.*

Some stakeholders referred to the Walk-in Centre's capacity to alleviate pressure from the emergency department, with the belief that this is an unrealistic expectation, as those patients who present to emergency department and are triaged as category 4 and 5 are often not suitable for general practice or the Walk-in Centre:

*Stakeholder: It's been proven in every attempt. If you look at the group of patients that present to tertiary Emergency Department and are rated Cat Four and Five and compare that to general practice presentation it is completely different ... The rate of patients requiring urgent imaging, requiring a procedural intervention, requiring immediate analgesia is totally different.*

From a primary health care perspective, some stakeholders felt that the Walk-in Centre may impact adversely on the relationship patients have with their regular GP, particularly if those patients had long term conditions that were being managed in general practice.

## Inter-provider agency networks and relationships

### *Organisational input into Walk-in Centre*

Most stakeholders believe that their organisations have had ample opportunity to have input into the development and ongoing operation of the Walk-in Centre.

*Stakeholder: We had a presentation a couple of years ago, about November 2008, when it was first thought of after the Health Department had gone off and looked at them in the National Health Service in the UK. We provided feedback to that discussion paper, we've had other submissions that we've made. We've had access to... we've talked about it with the Health Minister and the Chief Exec of A.C.T. Health. We've got consumers involved on the Clinical Advisory Committee. And we've got a consumer involved in the Steering Committee for the evaluation.*

*Interviewer: And are you happy with the level of input that you've been able to have into the operation of the centre?*

*Stakeholder: Oh absolutely. I mean there's been complete transparency, openness. On a couple of occasions for whatever reasons there hasn't been a quorum at meetings and we've have very frank discussions, which were un-minuted obviously, and that's been great. So I've found that the people have been absolutely responsive so if I've asked a question which has required a written answer with documentation it's with me two or three days later by email. So very well run.*

A number of stakeholders had invested a lot of time, some stating a need for funding to support their input in the future:

*Stakeholder: We've been quite highly involved in the Walk-in Centre from the beginning. It was a significant amount of work on our part that we were asked to do and that was out of our... we've got no extra staff to do this ... it was a lot of work and I guess if you're evaluating the role of other departments in the hospital being involved in this type of work, I guess actually allocating funds to fund staff to do this would be something that I would suggest because and I know that's what happened with a lot of the other people involved, so the physios and everyone. It was just expected to come out of time.*

Some stakeholders are satisfied with the level of input they had during the development of the Walk-in Centre. They are also satisfied with the fact they do not have an ongoing role in regard to the Walk-in Centre; however, are willing to have input if and when required.

Two stakeholders are dissatisfied with the level of their involvement in initial consultations regarding the Walk-in Centre. They also stated that they have no relationship with the staff or management from the Walk-in Centre and have not been contacted since its opening.

### *Organisational relationships with the Walk-in Centre*

Most stakeholders are satisfied with the relationships they have with the Walk-in Centre:

*Stakeholder: It was a really significant amount of work, but we've had a very good relationship with them and they understand its work on top of what we normally do and it's been very amicable, but I guess it could have potentially not been.*

*Stakeholder: I actually think it's really good. And I think we've, I think, maintained quite a good strong relationship with them. And we're happy to provide advice and information on anything that they feel we can assist them with ... in terms of our actual engagement with them I feel that we probably have a good relationship and we communicate well and you know I don't see a problem with our relationship with them at all ... And therefore if we can input to the Walk-in Centre that's going to improve the patient's journey or the patient's outcome then that's probably the main reason that we've really gone out of our way to maintain that relationship.*

### **Relationship between The Canberra Hospital Emergency Department and the Walk-in Centre**

There were mixed views about the relationship between the emergency department and the Walk-in Centre. The relationship seems to have matured and is improving:

*Stakeholder: And in another sense they're a professional group of people that we refer patients to which we do and they refer to us and we have a very cordial relationship with them, they ring we answer, we ring them they answer.*

*Stakeholder: There were some teething problems initially but I think that's gone. I mean there's no problem in the relationship from that point of view. They do a job, we do a job, we both talk to each other, there's not criticism of the job that they do. The only criticism, if there is one, at our end it's at a high level of the actual function, not the ... The relationship is fine.*

*Stakeholder: Hmm. OK. Well, as... it was always tense before we started. They declared that they didn't want us to be co-located. Since launch mostly they've been very reasonable and helpful ... I still think they could be sending us a lot more clients than they do, if they're serious about offloading pressure.*

*Stakeholder: I guess the main one would be the Emergency Department, and I think they probably had quite a love/hate relationship to start up with ... So I think both services have worked really hard, and where we probably first saw that the redirections to the Emergency Department were perceived to be quite high, that wasn't necessarily because of the physical location – it was more the presentations to the Walk-In Centre were not appropriate for what they were allowed to deal with. I think there is still some concern around the Walk-In Centre and the workload being put onto the Emergency Department from a medical point of view. I think that's more perceived than real ... So I think the Walk-In Centre and the Emergency Department, their relationship is growing, and it's getting better, but we can't stop people going to the Emergency Department if we said go to your GP, and they think well, I'm here anyway; I'm just going to walk up the hill to the Emergency Department. But I think that's getting better.*

### **Community perception of the Walk-in Centre**

Most stakeholders believe those in the community who are aware of the Walk-in Centre are supportive of it; consumer representatives state there is overwhelming support for it.

*Stakeholder: I think they perceive it extremely well. The feedback from the patients and the community has been overwhelmingly positive. Very few complaints and the majority of the complaints have been suggestions, so 'why can't you do this?' or 'can you do this?' or it's to do with waiting times when*

*they've been short staffed or something like that and so very little negative feedback from the community and I think it's a fantastic resource for people who... people just can't get into a GP urgently in this city. I think from that perspective it's been really good. The thing that I think is probably, its downfall is where it's located. It's not easy to access. You can't walk-in.*

Two stakeholders believe that patients will be satisfied with the Walk-in Centre because it is a free service; however they do not believe this satisfaction equates with quality care.

There is a significant perception that the community has not been adequately informed. A number of stakeholders believe ongoing and improved marketing could improve public awareness of the Walk-in Centre:

*Stakeholder: You know there's certainly some people that do go there but most of the people that I see ... they say oh what's that, where is it? So there is still, you know they certainly could do more advertising into the community, I certainly think so.*

*Stakeholder: There perhaps could be more and regular community announcements or advertisements about, particularly coming up to winter, about who they are, where they are and what they do. I know that for a while buses had posters on them and things like that. But I think there needs to be a little bit more community information, education given.*

*Stakeholder: I know there has been some confusion, we had heard that a consumer had gone to the Belconnen Community Health Centre looking for the Walk-in Centre and one of the people who works in the Civic Health Centre had told me that they'd had a walk-in as well looking for a Walk-in Centre. So the message is out there in some way but at the same time it's not clear that it's only available at the hospital ... we're very hopeful that it will change. It would be wonderful to have a Walk-in Centre as part of every enhanced primary health care centre that the government sets up.*

*Stakeholder: A lot of people don't know about it. I get in and talk to every taxi driver about it, or if I meet people I tell them about it.*

*Stakeholder: The only couple of negative reports that I've heard have been because people have not understood the scope of practice, so they've been expecting a lot more and I think it needs to be clarified that the Walk-in Centre is not to become your go to every time instead of a GP place.*

### Consumer input into Walk-in Centre

Responses to this question were varied; most stakeholders acknowledged the role of the health care consumer representatives during the development of the Walk-in Centre and on the Clinical Advisory Group, whilst some referred to patient feedback to the Walk-in Centre.

*Stakeholder: Well, I think they certainly have the opportunity to provide feedback, and there's feedback forms and things there, and they do get feedback. And I know I've been at meetings where they show what people have written, and try and address them, and write to them.*

*Stakeholder: Well yes by presenting, like if there were more that came there the more they'd say well yes that's, like it would increase the numbers. So yes, just by going there is enough to influence.*

*Stakeholder: Well certainly my understanding is that they've engaged with consumers quite well. There's a consumer representative on the Clinical Advisory Board so I think at that level there's the opportunity for the community to be engaged. I guess we could always all engage more with the community in terms of what we're doing so that they understand what we're trying to achieve*



*but I don't see that they haven't done that. It seems to me that they've done that quite well and they've got their frequently asked questions and their website so it appears that they have.*

Some believe that the community has little opportunity for input into the Walk-in Centre:

*Interviewer: Do you think the community has an opportunity to influence policy or planning or the way the Walk-in Centre's run?*

*Stakeholder: They could do. I guess the short answer is no [laughs]. There's so many ... bits that go with that like what the community wants. They always have bigger expectations than perhaps what can be delivered. And they're quite [inaudible] you're allowed to be an involved consumer and have expectations but...*

*Stakeholder: The broader community, no, because... but consumer representatives ... and other stakeholders, they can certainly influence it. Yeah, so we need to work more on that community engagement. We all do.*

### Perceived impact on other health care providers

Some stakeholders believe that the Walk-in Centre has increased pressure on The Canberra Hospital emergency department:

*Stakeholder: But my overall impression of how that has been is that we seem to get a lot of patients that have gone to the Walk-in Centre, so they've done the right thing but somehow they are referred up to us. And so it seems to add extra work in many instances. I often wonder whether these people have come from out of area to the Walk-in Centre and then found themselves to our Emergency Department so I wonder, you know I don't have any data to back that up, but you know I wonder whether sometimes even added to our issues.*

However one stakeholder cited data, which provided evidence that a large number of referrals to emergency department are appropriate:

*Stakeholder: The data suggests that those referred from Walk-in Centre to ED are appropriate – 25% are triaged as Category 3 in ED.*

One stakeholder referred to additional pressure placed on outpatient clinics at The Canberra Hospital coming from Walk-in Centre referrals:

*Stakeholder: There's been a bit of feedback and I don't know if it's come up in other things, some of it they may be putting weight onto other areas so you know there's been some feedback from orthopaedics and plastics for example, that their Registrar review clinic is a little bit swamped with minor injury stuff that has been, because if they can't deal with it there we initially said we didn't want to deal with that so they of course refer it to plastics who of course aren't prepared to deal with it over the phone so they send it to Registrar review clinic. So you've probably got people that have been, wounds delayed for 12 hours for review that could have been managed by us or managed by a number of other centres that they've driven past to get to the Walk-in Centre*

In terms of general practice, the number of patients seen in the Walk-in Centre is not considered large enough to have had a noticeable impact at this stage:

*Stakeholder: I can't see how, with the numbers and the volume, it could have had an impact.*

As noted earlier, two stakeholders believe the Walk-in Centre has had a negative impact on general practice through a loss of funds spent on the Walk-in Centre that could otherwise have been invested in general practice in the ACT.

## Performance assessment

When asked about internal performance assessment, managers are clear on what these are and how they are measured:

*Stakeholder: We... have key performance indicators. They're very clear – they're about as clear as you can get really, and I'm delighted because I like working in that environment.*

*Stakeholder: So I guess looking at its financial performance; it's achieving its KPIs that were predetermined when it was set up ... I've been happy with the way that the throughput has been going through, and the sort of time that staff have spent with their clients. I wouldn't say that they've spent too long or too short a time – I would say it's been highly appropriate, whatever they've spent, depending on that situation.*

## DISCUSSION

### Limitations

A number of stakeholders did not respond to recruitment invitations. The absence of their input into this study is identified as a limitation to the data collected. A second limitation is the absence of data measuring the perception and satisfaction of general practitioners. This information would provide a valuable perspective regarding the perceived effectiveness of the structures and processes of the Walk-in Centre. A third limitation is the capacity to measure the actual impact the Walk-in Centre has had on other health care providers. This has been raised by stakeholders, but cannot be quantified within the terms of this current evaluation. Finally, community perceptions of the Walk-in Centre have been measured in terms of patient satisfaction; however it is not within the terms of this evaluation to collect data from non-attendees of the Walk-in Centre. Community perceptions as discussed by stakeholders are therefore anecdotal and cannot be discussed in light of evidence.

As a measurement of the Walk-in Centre's capacity to provide primary care to patients, families and the community, stakeholders' perceptions clearly indicate areas where they believe the Walk-in Centre is achieving this and areas where they believe implementation can be changed or improved to meet the overall objectives of the Walk-in Centre.

### Model of care

Stakeholders generally supported the nurse-led model of care; however the scope of practice is considered inadequate to enable optimum implementation of this model in the Walk-in Centre.

It must be noted that the model of care under evaluation is not the model of care intended for the Walk-in Centre, as described in the *ACT Health Walk-in Centre operational model of care*.<sup>55</sup> This model of care includes the full implementation of both advanced practice nurse and nurse practitioner roles. At the time of evaluation, only the advanced practice nursing roles have been implemented at the Walk-in Centre. Discussions of the model of care with stakeholders are therefore in relation to a nurse-led model of care utilising advanced practice nurses. The presence of a nurse practitioner in the Walk-in Centre (not practicing as a nurse practitioner) provides a source of education and support for the advanced practice nurses, which they would not otherwise have.

The lack of implementation of the nurse practitioner role was a source of dissatisfaction for most stakeholders; considered a lost opportunity. Factors essential to the implementation of this role are discussed in the nurse satisfaction chapter of this evaluation. The implementation of this role and inclusion of it in future ACT Walk-in Centres needs to be considered in terms of the capacity nurse practitioners have in the provision of primary care services and the scope of primary care services to be provided at Walk-in Centres.

Implementation of the nurse practitioner role would address issues of inadequate scope of practice identified by stakeholders. In nurse-led convenient care centres in Canada, nurse practitioners are integral in terms of leading clinical decision making and developing best practice, which guide scope of practice and service delivery.<sup>56</sup> However, this author highlights the fact that “autonomy is not interchangeable with isolation. Nurse practitioners have very high levels of decision-making, accountability, and responsibility, and value both autonomy and collaboration with other healthcare professionals”.<sup>56</sup>

One proposed alternative, which provides a solution to the advanced practice nurses’ limited scope of practice, was the inclusion of a doctor in the model of care. The presence of a medical source of ongoing education, collaboration and training has been identified as an important factor in implementing nurse practitioner roles;<sup>57,58</sup> however, this does not necessarily mean that a doctor needs to be physically present at the Walk-in Centre to achieve this.

### Processes of care provided

The protocols utilised by the Walk-in Centre nurses are perceived by stakeholders to be both a source of support and limitation for the nurses working at the Walk-in Centre. Closely related to this are the number and nature of referrals generated as a result of the protocols. Whilst they are a valuable, supportive risk management strategy, they are perceived to limit the capacity of the nurses to utilise clinical decision skills, which would provide an increased scope of practice, ultimately improving access to primary care for those attending the Walk-in Centre. Whilst nurse practitioners do not work in accordance with protocols in the ACT, this new autonomous role for advanced practice nurses requires a balance between safety and autonomy. This needs to be explored and developed to optimise the use of advanced practice nursing skills in the Walk-in Centre.

The limited capacity for Walk-in Centre staff to access medical imaging services for patients is another issue limiting the scope of practice of the Walk-in Centre and subsequently its capacity to provide improved access to primary care services for the community. A review of this aspect of the service, with an aim at improving access will address stakeholders’ concerns.

### Information systems

Stakeholders’ perceptions of the inadequate nature of the Walk-in Centre CDSS refer to its capacity to interface with other systems and to generate referrals and specific data reports. The use of software with well-integrated clinical decision support facilitates documentation, electronic referral and peer review.<sup>59</sup> Additionally, well integrated systems can enhance patient safety through sending electronic prescriptions to pharmacies and providing automated medical record and medication history checks.<sup>59</sup>

### Staffing

Access to ongoing education and training for staff was raised as problematic by staff and managers in the staff satisfaction aspect of this evaluation and is discussed more extensively in that chapter. This was also identified by managers in the NHS Walk-in Centres, due to the diversity of staff experience and qualifications and the development of training to meet different needs.<sup>60</sup> Stakeholders’ concerns related to the diversity of skill mix at any time at the Walk-in Centre can be linked to this and is an issue which requires careful consideration and planning.

When considering this issue in regard to NHS Walk-in Centres, Rosen and Mountford found that “agreement is required on the competencies required for Walk-in Centre nursing and on appropriate ways to develop and support nurses in their practice”.<sup>32</sup>

## Organisational input

Most organisations are satisfied with the level of input they have and their ongoing relationship with the Walk-in Centre. These relationships could be further supported through the provision of funding, when organisational input requires training and ongoing support of Walk-in Centre staff.

The capacity for the Walk-in Centre to foster its relationships with other organisations and health care providers has been enhanced through the development of these relationships throughout the first 12 months of operation. This capacity can be extended to organisations resistant to the model of care and overall concept of the Walk-in Centre, which require the opportunity to further engage with the Walk-in Centre and the provision of ongoing opportunities for organisational input.

## Community perceptions of the Walk-in Centre

Continued community promotion of the Walk-in Centre as an alternative venue to access primary care services, with clear definition of its scope of practice, is considered an important strategy to harness community support and use of the Walk-in Centre.

## Access to primary care services

Overall the Walk-in Centre is perceived to have improved access to primary care; however it is perceived that this impact could be greater if the scope of practice of the staff were extended and expanded. The view of two stakeholders that funding allocated to the Walk-in Centre might have been better spent on existing primary care services was also a perception of health care providers in the United Kingdom, when discussing NHS Walk-in Centres.<sup>61</sup>

The perception that, in addition to increasing access, the Walk-in Centre might in fact be increasing demand for primary care services is also one put forward in regard to NHS Walk-in Centres. It is suggested that this could be due to the medicalisation of minor health problems that were previously managed effectively at home.<sup>62,63</sup>

The location of the Walk-in Centre at The Canberra Hospital was referred to as a risk management strategy by one stakeholder. Whilst this strategy might be risk-averse, it is a source of dissatisfaction for many stakeholders. Evaluation of Walk-in Centres co-located with emergency departments in the NHS did not reveal evidence of effect on the emergency departments. However, these do not make good comparators as they were not nurse-led; they were staffed 40% by doctors. Additionally, patient attendance at these centres was usually determined through a triage process as opposed to the patients' choice to attend a Walk-in Centre.<sup>64</sup>

## CONCLUSION

The areas where the Walk-in Centre is perceived to have good capacity for achieving its objectives are: the physical facilities and equipment, the use of protocols as a risk management strategy, the quality of care provided and a general perception of improving access to primary care.

This capacity of the Walk-in Centre is perceived to be diminished due to the restricted capacity for nurses to utilise clinical decision-making skills through the necessity to conform to protocols. In addition to this, inadequate software and referral systems further diminish the capacity of the Walk-in Centre to achieve its objective. There is a perception that an alternative location for the Walk-in Centre would increase convenience of access for the community and address perceived issues created due to its location on a hospital campus.

The lack of implementation of the nurse practitioner role has resulted in the implementation of a model of care different to that proposed in the document *ACT Health Walk-In centre* –

*operational model of care.*<sup>55</sup> The perceptions of stakeholders informing this evaluation are therefore based on an advanced practice nurse-led model of care.



# Chapter 7 The Impact of the ACT Health Walk-in Centre on the ACT Emergency Departments

## BACKGROUND

One of the objectives of the Walk-in Centre, and in particular of its placement within the TCH precinct, was to take some load from the emergency department at the hospital (the TCH-ED) by addressing the needs of some of the Triage Category 4 and 5 patients presenting at TCH.

To address whether this has occurred is complex, and is likely to be somewhat indeterminate for a number of reasons, including that the Walk-in Centre throughput is always likely to be much less than that of the ED, and that ED trends are somewhat volatile.

We address this question from two perspectives:

- > Firstly we look at the levels of activity in the two emergency departments in Canberra (TCH and Calvary Hospital) to see if there are any deviations from trend in the period of the Walk-in Centre.
- > Secondly we examine Walk-in Centre patients who state that they would have attended an ED had the Walk-in Centre not been available, and compare this number with the number of patients who are referred from the Walk-in Centre to an ED.

Both these approaches are fraught. The former requires us to estimate what the ED usage would have been had the Centre not been present. The latter is restricted in that only inbound patients are asked where they would otherwise have attended while outbound patients comprise the majority of referrals/redirections to the ED, and secondly because it is not clear that patients will necessarily be able to correctly answer the hypothetical question of “what they would have done”.

It is of note that A/Prof Drew Richardson of the ANU Medical School and The Canberra Hospital Emergency Department has recently presented material to conferences on the early experience of the Centre for the TCH and shown:

- > Significant numbers of referrals or redirections from the Centre to the TCH-ED
- > Total TCH-ED numbers increased at the time of the commencement of the Centre
- > This increase was largely in the triage category 5 (non-urgent – to be seen within 120 minutes)
- > The majority of Centre referrals are placed in triage category 5, a view supported by the fact that only 3-5% of patients coming from the Centre to the ED are admitted to the hospital, a rate comparable with other ED category 5 patients and well below the category 4 admission rate of 12%.

While these facts support rather than prove the view, they have led him to the view that the Centre increased the ED presentations rather than reduced them. This does not reflect on the quality of care of Centre, but argues that there is “overflow” from the Centre to the ED due to the location, with Outbound patients in particular finding the ED convenient as they are in the hospital precinct but they are unable to be treated in the Centre.

The following analysis is based on data for the Walk-in Centre and the emergency departments to May 2011.

# ED PRESENTATIONS

The statistics on emergency department presentations are somewhat complex and not all relate to the potential Walk-in Centre client group.

ED presentations are classified firstly into 5 triage categories,

- 1.1. Resuscitation (to be seen immediately)
- 1.2. Emergency (to be seen within 10 minutes)
- 1.3. Urgent (to be seen within 30 minutes)
- 1.4. Semi-urgent (to be seen within 60 minutes)
- 1.5. Non-urgent (to be seen within 120 minutes)

Secondly they are classified into whether presenting at:

- 2.1. The Canberra Hospital
- 2.2. Calvary Hospital

Thirdly they are classified as:

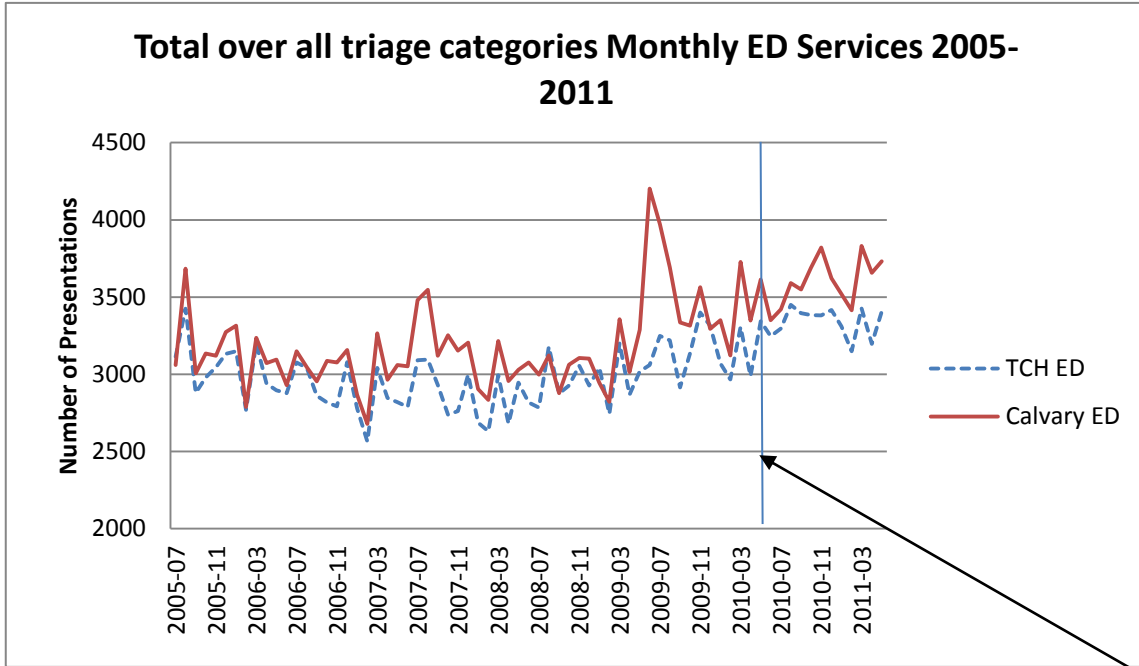
- 3.1. Admitted to this hospital (includes units or beds in ED)
- 3.2. ED episode complete-departed-no admission or referral
- 3.3. Referred to another hospital for admission
- 3.4. Did not wait to be attended by a health care professional
- 3.5. Left at own risk after being seen-before episode completed
- 3.6. Died in ED as a non-admitted patient
- 3.7. Dead on arrival, not treated in ED

Only categories 3.2, 3.4 and 3.5 are considered as the Walk-in Centre is predominantly dealing with low acuity patients who do not require admission to hospital. It is assumed that those admitted to hospital (categories 3.1 and 3.3) were too ill to be assessed and treated in the Walk-in Centre and would have gone to ED regardless of the Centre, as were those in categories 3.6 and 3.7.

As the objectives of the Centre relate to reducing triage category 4 and 5 patients (i.e. categories 1.4 and 1.5) these are analysed separately. However anecdotal evidence suggests that the boundaries between triage categories are somewhat porous and inconsistently applied, so we also compare totals across all triage categories.



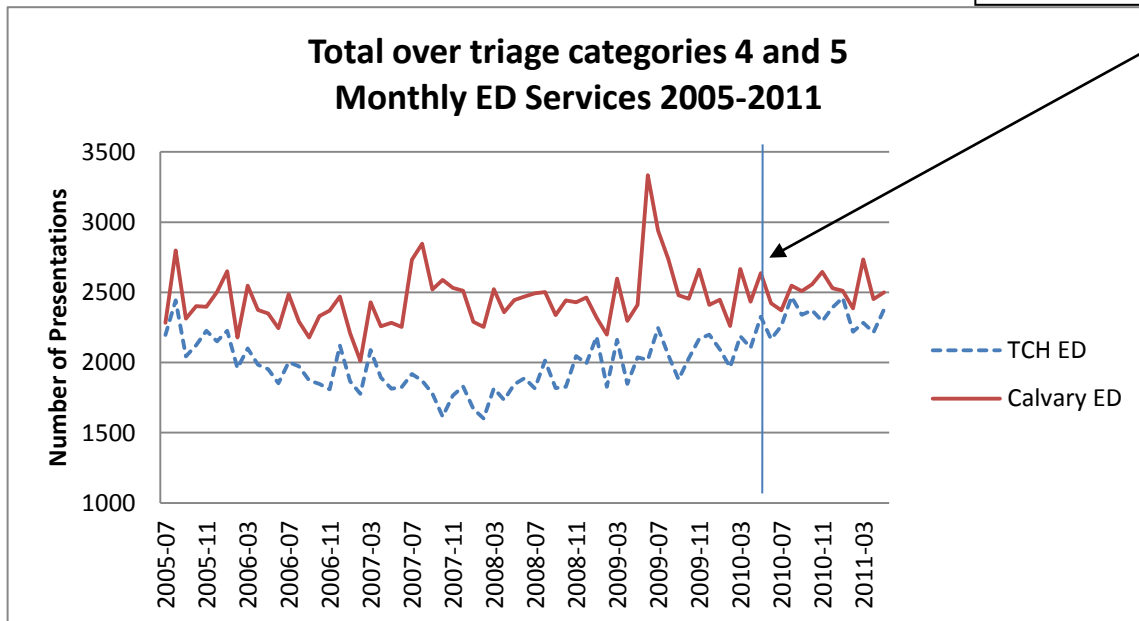
Figure 34: Emergency Department services – all triage categories



Note: includes only those presentations with episodes completed in ED or left of their own volition prior to completion of treatment

Date of commencement of the Walk-in Centre

Figure 35: Emergency Department services – all triage categories



Note: includes only those presentations with episodes completed in ED or left of their own volition prior to completion of treatment

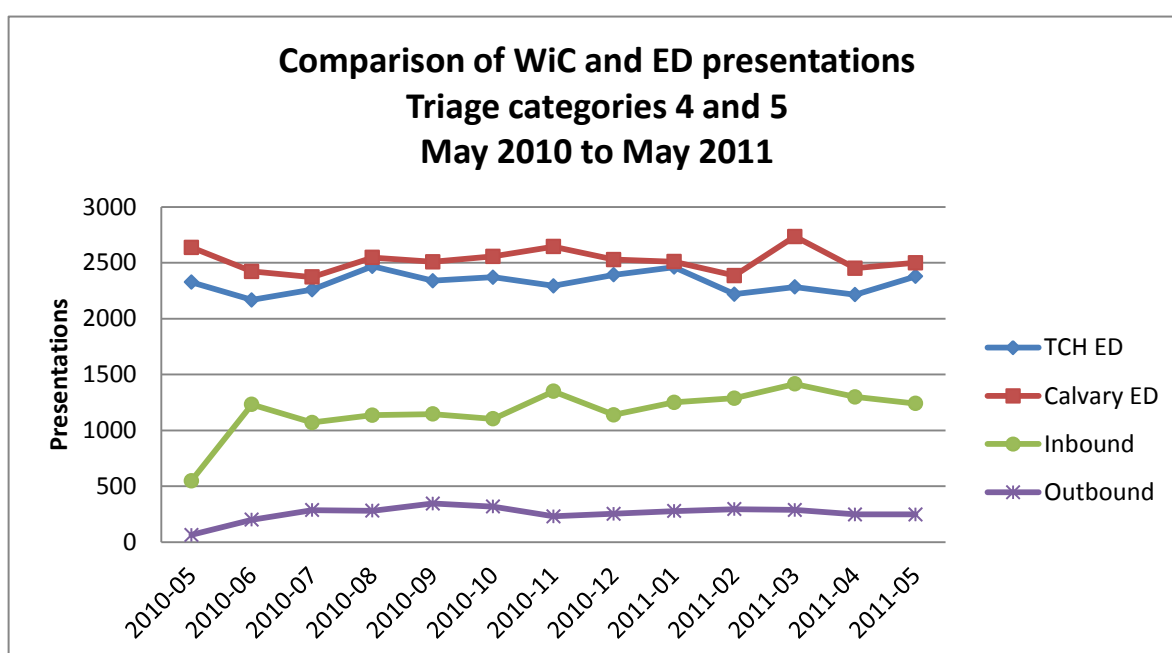
The patterns in these charts show interesting similarities and differences between the reported levels of activity in the two emergency departments. Both the overall and the triage 4/5 show substantial month to month variation beneath which can be seen broad trends. Figure 34 shows the overall TCH activity levels broadly declining to the end of 2007 and thereafter broadly increasing. Calvary follows a similar pattern although the decline is less pronounced and the rise arguably begins a year later. Calvary also has much bigger

variations in presentations, particularly in mid 2009. In both cases the period post the introduction of the Centre broadly follows previous patterns, although the TCH-ED appears to step up in mid 2010 then stabilise to a degree. More detailed analysis is needed to observe whether the numbers are above or below trend.

Figure 35 which relates to the Triage Category 4 and 5 patients shows a similar story for the TCH, but the Calvary pattern is less clear with numbers appearing to vary around the 2,500 per month apart from the mid 2009 major peak. Again, any variations from trend post the introduction of the Centre cannot be identified visually for Calvary, but TCH-ED appears to have increased around the time of implementation of the Walk-in Centre although growth is greatly reduced in 2011.

Before looking at comparisons of predictions and outcomes we compare the ED and Walk-in Centre presentations over the period of the activity of the Centre to see if there are any apparent month by month relationships.

**Figure 36: Emergency Department services – all triage categories**



There are no obvious visual correlations (although the November and March peaks/troughs are interesting). Simple correlations between the ED and the Walk-in Centre levels are all insignificant (which is unsurprising with only 12 observations and no strong relationships visible) but nonetheless it is of note that the correlations of the Inbound with the TCH is negative, the Outbound with the TCH is positive and both Inbound and Outbound have negative correlations with the Calvary presentations (although the inbound correlation is extremely small).

If these correlations were sustained with a longer sequence of data (and of course this may not occur) it could support a view that Centre was drawing patients from Calvary (and 21.4% of ACT patients come from Belconnen, Gungahlin/Hall or North Canberra), and that while Inbound patients may reduce TCH-ED activity in net terms, Outbound patients may be adding to TCH-ED presentations.

## SOME ALLOWANCE FOR SEASONALITY

In the previous section we looked at longer term patterns to see if there was any obvious pattern of a step up or down in ED activity at the time of introduction of the Centre, and whether patterns within the time of the Centre's operation could tell anything.

In this section we look at data for the period from May to following April for the years 2008 to 2010 to observe change and in particular any step up in 2010. This examination of full years should remove seasonal effects.

**Table 16: Comparison of ED Presentations for 12 month periods: May 2008 to 2010**

ED presentations in Triage category 4 and 5 and overall from May to April								
Year from May	Category 4		Category 5		Total 4/5		Overall total	
	TCH	Calvary	TCH	Calvary	TCH	Calvary	TCH	Calvary
2008	18,756	18,682	4,513	10,314	23,269	28,996	35,359	36,506
2009	20,377	21,590	4,605	8,518	24,982	30,108	37,642	41,014
2010	20,471	22,964	7,326	7,339	27,797	30,303	39,996	43,083
Change 2009 to 2010	0.5%	6.4%	59.1%	-13.8%	11.3%	0.7%	6.3%	5.0%
Change 2008 to 2009	8.6%	15.6%	2.0%	-17.4%	7.4%	3.8%	6.5%	12.4%
<i>Note: adjustment to Calvary 2009 to remove extreme peak.</i>								
<i>Note: does not include admitted patients or deceased patients</i>								

Table 16 shows firstly the instability of the measures, with TCH overall growing 6.5% between 2008 and 2009 (before the Centre was established), but the Category 4 presentations growing by 8.6% while Category 5 presentations grew by only 2%. The data for TCH however shows very large growth in Category 5 presentations at TCH between 2009 and 2010, with growth for categories 4 and 5 combined significantly above the previous year's growth rate. Looking at the overall total numbers of presentations however we see that the growth is slightly less for May 2010 to April 2011 than for the same period in previous year.

Figures for Calvary appear to show shifts between Categories 4 and 5 between 2008 and 2009. Although these numbers are so large as to suggest some structural or measurement change, the overall growth in activity in the period of operation of the Centre is clearly smaller than growth in the previous year. The possible structural factors make it difficult to interpret this result with any certainty, although it is not inconsistent with the view that the Walk-in Centre has drawn some patients from Calvary ED.

## ED PRESENTATIONS COMPARED TO SIMPLE PREDICTIONS

In order to attempt to compare actual ED presentations with the likely outcomes had the Centre not been present, we estimate simple linear trend lines for TCH and Calvary separately and for both triage category 4/5 and across all triage categories. Observation of Figures 34 and 35 suggests a major change in trend for TCH at the end of 2007 so the trends are estimated for the period January 2008 to April 2010. While the Calvary patterns are less clear the same period is used for consistency. As the Calvary data has major "spike" in mid 2009 which is clearly not part of the trend, the data for June and July 2009 are smoothed before estimating the trend. Figures 37 and 38 show the results of this analysis.

Figure 37: Predictions compared to actual outcomes – all triage categories

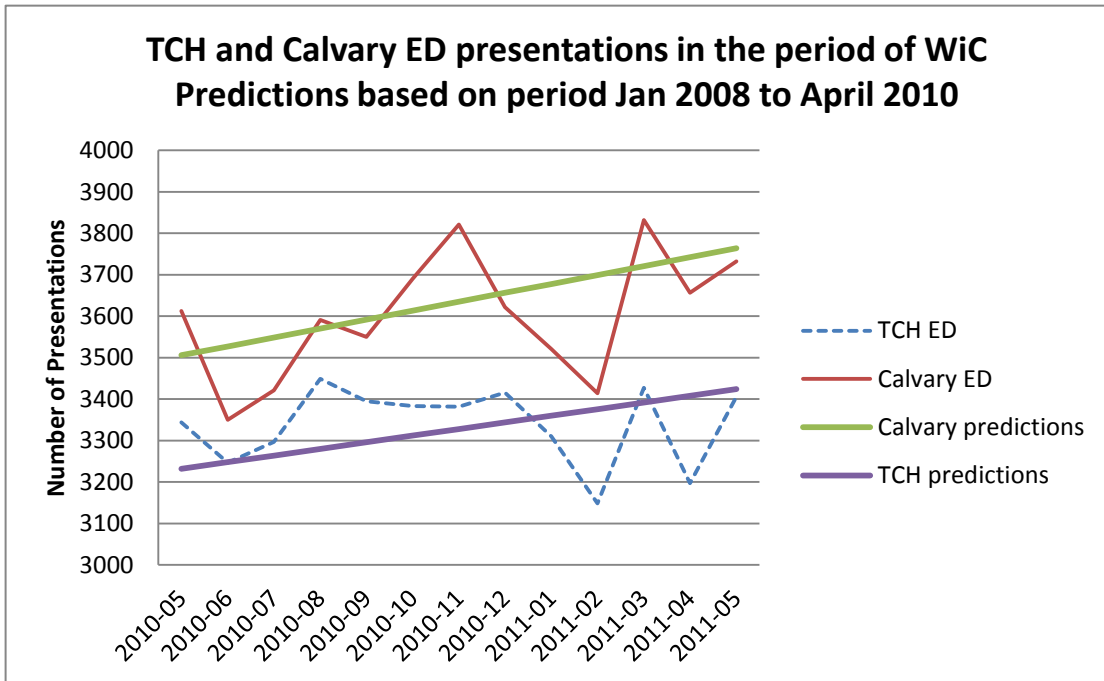
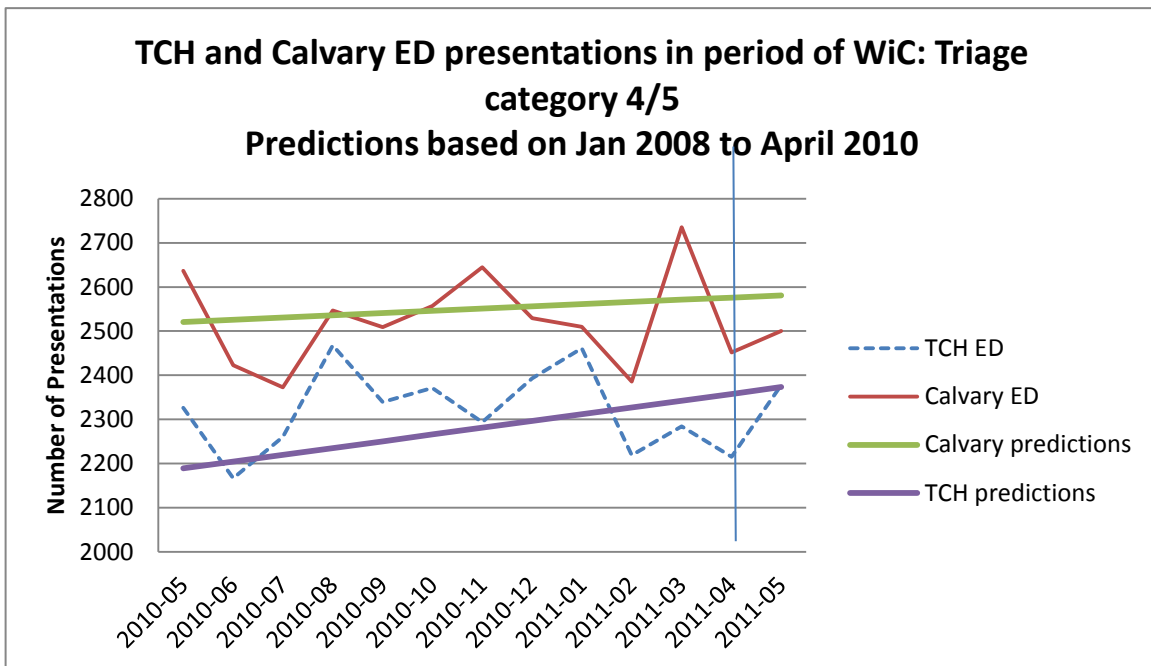


Figure 38: Predictions compared to actual outcomes – triage categories 4/5



Both charts show the TCH-ED actual clearly above trend for most of the period, although the falling below trend in 2011. The total analysis suggests that over the 13 months May 2010 to May 2011 the TCH was only 139 presentations (0.3%) above the previous trend and the triage category 4/5 were 520 presentations (1.7%) above previous trend. Calvary on the other hand (after removing the spike in mid 2009) showed below trend results early in the period and above trend later in the period. The net effect was a below trend (438 and 358 presentations respectively for the two measures).

This simple analysis confirms that the TCH-ED presentations were above the trend patterns of previous years in the period of the activity of the Centre, and suggests that the Calvary ED presentations may have been below trend. As is visible in Figures 34 and 35 the Calvary presentations are very volatile, and the turning point between different trends is much less clear than the TCH, so the results depend greatly on the period on which trend estimates are based. Most alternate approaches suggest a higher trend line and hence a bigger net fall in the Calvary presentations.

## PATIENTS “INITIAL INCLINATIONS”

Patients who register at the Walk-in Centre as Inbound patients are asked where they would have gone had they not attended the Walk-in Centre. Outbound patients are not asked to register and so this information is not sought from them. All patients, however, should have the result of their visit recorded as either a completed service with no further assistance required, or if they are referred or redirected to another service provider, be it a GP, CALMS, the ED or somewhere else. The referrals or redirections are recorded for both inbound and outbound patients, but whether they follow those referrals or redirections is generally not known.

The initial inclination of the Inbound patients is not available in the data extract provided for this analysis, but is available in a standard report from the system. This report shows 2,104 people reporting that they would have gone to the ED with 217 of these redirected to ED and 404 others redirected to ED.

On the other hand the data extract shows 811 Inbound patients redirected to ED. While it is not obvious why these numbers differ, in either case many fewer patients are redirected to the ED than stated that they would otherwise have gone there.

Further the Centre records the source of “referral” to the Centre, which is predominantly friends and family, but also includes 455 (26 Outbound) patients who have been referred to the Centre from one or other ED.

Almost half of Outbound patients (1,357 or 41%) who are out of scope of the Centre for a range of reasons, are redirected to ED. Some are too ill, some are too young, some have conditions which are out of scope without being very ill. It is not known how many of these would otherwise have attended ED or done something else, but this is a large proportion of the patients who are out of scope of the Walk-in Centre.

One reason for redirection to ED rather than elsewhere is that patients arrive at the Centre after hours at which time other sources or care are not available. For both Inbound and Outbound patients there is a higher percentage of referrals to ED at night and on weekends than at other times.

In summary using the Walk-in Centre information:

1. Number Inbound referred from ED to the Centre: 429
2. Inbound:
  - a. “Would have gone to ED”: 2,104
  - b. Redirected to ED (mostly after treatment): 811
  - c. Net 1,293 less sent to ED
3. Outbound
  - a. Number would have gone to ED not known (not asked)
  - b. Number directed to ED: 1,357
  - c. Net impact unknown but less than 1,357 as some would have gone to the ED in any case and some redirected would not take the advice

The net effect of these numbers depends on whether the 2,104 who stated they would have gone to ED are in fact making a correct judgement, how many of the 1,357 Outbound who were redirected to the ED would otherwise have gone there, and how many of both groups who were redirected to ED actually took the advice. If all the apparent numbers were reflected in behaviour there would be a net reduction in ED demand of 429. However, the overall impact of the Centre could range from a net saving to the ED of 1,722 at one extreme to a net addition of 1,739 at the other depending on assumptions about the behaviour of patients.

Many combinations of the assumptions about the application of these numbers are possible. If for example half of those who claimed to have been going to ED indeed were going, and half of the outbound patients redirected to ED would have gone in any case, the net impact is almost zero. On the other hand if half of those claiming to be going to ED were mistaken but none of the outbound patients would otherwise have gone to the ED there would have been a net impact on the ED of 687 additional patients. The growth of 520 category 4 and 5 patients at TCH-ED estimated using the trend analysis could therefore have been achieved with a pattern of this nature. While real growth in TCH-ED is very likely, there is still a question of whether there has been a shift in the trend patterns for some other reason than the opening of the Centre.

## CONCLUSION

As noted in the introduction to this section any analysis of this data is fraught. However it appears:

- > The number of Category 4 and 5 presentations at the TCH-ED, mainly due to the Category 5 presentations, has increased materially above trend in the period of activity of the Centre;
- > The numbers of Category 4 and 5 presentations at the Calvary ED appears to have declined relative to trend;
- > Depending how trend is viewed, the overall activity at the TCH-ED may have increased or may not – overall growth in the year to May 2010 to April 2011 is no greater than the previous year
- > Overall numbers at Calvary ED appear to have declined relative to trend;
- > Considering the known numbers referred between the Centre and the ED, the numbers who stated that without the Centre they would have gone to the ED (although patients ability to provide this information is uncertain), the lack of even this information for Outbound patients, and lack of information on whether patients follow redirection/referral advice:
  - The most likely outcome impact of the Centre on the ED, based on the available flow information, is that the Inbound patients reduce pressure on the ED, but that;
  - The Outbound patients add to pressure on the ED as they have come to the hospital precinct and when they were unable to obtain care at the Centre the ED becomes a more viable option than had they sought their initial assessment elsewhere;
  - The net impact could range from quite large increase in ED activity to a large decline
- > Overall it appears most likely that while treating some patients who would otherwise have gone to the ED, the Centre has drawn more patients to the hospital campus and then to the TCH-ED than would otherwise have been the case. While the size of the net effect is not able to be reasonably estimated from the flows data, the estimated

small growth in TCH-ED activity shown in the trends data is clearly within the range of values which could be derived from the flows data.





# Chapter 8 Costs and Cost Implications of the Activity of the Walk-in Centre

## MAIN ISSUES AND BROAD CONCLUSIONS

### Background

The set up and running costs of the Walk-in Centre (WiC) are known and are discussed below. The broader financial implications of the activity of Walk-in Centre, however, are much more difficult to identify and analyse, and depend to a large degree on the “perspective” taken and the view of costs in the emergency departments which in practice tend to be very stable. The first section (Background) of this Chapter summarises the results of the analysis with a focus on the ACT Health financial perspective and the assumption that costs in the Emergency Department do not change with volume changes of the order which could potentially be caused by Walk-in Centre. The second and third sections (‘Costs of the Walk-in Centre’ and ‘Costs of GP and ED treatment’) describe the source of the basic costing information and the issues in relation to the time frame of the available data are addressed in the fourth section (‘Costing time-frame’). If the perspective of the whole health system is taken so that GP costs need to be considered, or if allowance is made for notional changes to ED costs, the analysis is very complex and requires many assumptions. The remainder of the Chapter from ‘Detailed analysis of flows’ addresses these more complex perspectives and options, but may not be of interest to readers who are interested only the perspective of ACT Health costs.

As an example of the nature of the complexity faced in the later sections, Walk-in Centre will have fully treated some patients who would otherwise have gone to a GP, and it will have treated some patients who would have gone to a GP but need to go a GP for follow-up. It will have treated some people who would probably not have gone to a health professional at all and who after treatment by the Walk-in Centre are still directed to go to a GP for follow up.

Further, while we can discuss the notional change in ED costs of increased or decreased patient loads, in practice the funding of EDs tends to be stable with waiting times rather than staffing levels varying with patient loads. This may change with large and sustained changes in patient loads, but as noted in the ED discussion the impact of the Walk-in Centre on the ED will be small in percentage terms.<sup>9</sup>

In considering the benefits (or the effectiveness) of the Walk-in Centre we are restricted at this stage to considering the numbers of services provided or the numbers of patients treated. There is no capacity to examine clinical outcomes and clearly no capacity to examine how clinical outcomes differ from the likely outcomes if care was provided by different services. In future studies it may be possible to compare patient satisfaction between different service providers, but it will always be difficult to follow up clinical outcomes, particularly when a major alternative to attending the Walk-in Centre is doing nothing.

Most of the data used in this analysis relates to costs and services for the period 18 May 2010 to 17 May 2011. Budget data was not readily available for this period so financial year figures are shown for comparative purposes only. Costing data for part months was estimated by pro-rating the expenditure for the number of days of activity.

Tables 17 and 18 below show the main results of the costing study, showing the cost per service of the Walk-in Centre, however addressed, falls between the costs of the ED and of

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<sup>9</sup> Even the highest estimate from the previous section of 520 additional The Canberra Hospital ED services over the period May 2010 to May 2011 amounts to 1.7% of total ED services and these are in the least demanding triage categories 4 and 5.

general practice. Table 18 shows the costs after allowing for any savings from the Walk-in Centre replacing ED or GP services, and any additional costs if the Walk-in Centre refers on patients who may otherwise not be referred. These costs depend on the perspective taken, with the view from ACT Health assuming ED costs are fixed leading to the highest overall cost per service, while potential savings from ED and from general practice lead to the lowest costs if a health system perspective is taken and notional ED costs included.

The costs in Table 18 also depend on assumptions regarding the actual flow of patients from Walk-in Centre. The results shown in this section assumes that all Inbound patients who stated they would have gone to the ED in the absence of Walk-in Centre would in fact have done so, and that all Outbound patients who were redirected to the ED would have gone there in the absence of Walk-in Centre. These assumptions therefore minimize the impact of Walk-in Centre on The Canberra Hospital (TCH) ED. Appendix D shows the results with different assumptions about the veracity of patient expectations, and the likely alternate behaviour of Outbound patients. Notional costs can change considerably depending on the assumptions, with generally higher average costs if more services are directed to the ED, however, with lower costs if it assumed Outbound patients would not have otherwise gone to the ED since with the additional ED activity the total number of services increases while the costs do not.

**Table 17: Unit costs per service**

Average cost per service of Walk-in Centre July-Dec 2010	\$196
Marginal cost per service of Walk-in Centre July-Dec 2010	\$138
Average cost per service of Walk-in Centre if operating at 80 services per day and full budget expended	\$114
Marginal cost per service of Walk-in Centre if operating at 80 services per day and full budget expended	\$79
Average cost per service of ED (triage 4 and 5)	\$281 <sup>10</sup>
Average cost per service of GP	\$45

**Table 18: Average cost per Walk-in Centre service net of ED and GP services saved or required**

Perspective	Cost per Walk-in Centre service	Total cost for May 2010 – May 2011
1. ACT Health perspective, assume <b>no change</b> in expenditure in ED	\$196	\$2.883m
2. ACT Health perspective, assume changes in ED activity lead to changes in costs	\$142	\$2.090m
3. Health perspective, assume no change in expenditure in ED	\$169	\$2.485m
4. Health perspective, assume changes in ED activity lead to changes in costs	\$116	\$1.696m

*Note: assumes Inbound patient views on where they would have gone in the absence of Walk-in Centre, and ignores Outbound patients*

If the perspective of ACT Health together with the view of no change in ED costs regardless of activity change is taken, the total costs are simply the costs of setting up and operating Walk-in Centre (outlined in 'Costs of the Walk-in Centre' below) and the volume of services. The figures under Perspective 1 only vary if it is assumed that a number of Outbound patients who had not planned to go to the ED are referred to the ED and treated there. In this case the number of services goes up at no extra cost, leading a fall in the average cost per service. If all the patients referred by Walk-in Centre (1,320 in the period July to

<sup>10</sup> As noted below, this figure assumes the existing ED mix of category 4 and 5 patients. The patients referred by Walk-in Centre may not follow this structure.

December 2010) went to the ED then the total number of services provided would increase at no additional cost, and the average cost per person receiving a service would fall from \$196 to \$180. This, together with a range of other examples, is shown in Appendix D.

### Costs of the Walk-in Centre

Information provided by ACT Health tells us that:

- > Set up costs comprise: \$2.174m capital and \$1.015m recurrent (although some of this recurrent may have become part of Walk-in Centre running costs in the first two months – we subtract the running costs for May and June from the \$1.015m)
- > Ongoing costs of \$2.528m per annum
- > With indirect costs of overheads – finance, Human Resources (HR), Information Technology (IT), policy, executive, etc. approximately 16% across all of ACT Health.

To calculate the actual costs for the first 12 months of operation we use monthly running costs data with the following adjustments:

- > The costs for May 2010 and May 2011 are prorated according the operating days
- > The costs for June 2010 are estimated from May and July figures, as the data for that month includes a very large set up payment
- > The substantial annual payment for computer maintenance is not made in this May to May period, but is made in June 2011:
  - o For the purposes of these calculations this payment is brought forward into the costs of the first year of operation as it will normally arise in any twelve month period and is only outside this period by “accident”

This methodology gives a total “actual” expenditure of \$2.140m, which is almost the same as the actual annual outlay for the 2010-11 financial year of \$2.183m. The budget allocation for 2010-11 is \$2.528m. The underspend in 2010-2011 is mainly in wages and salaries and in computer expenses. The details also show us that over the whole year the dominant costs are wages and salaries (73% including superannuation), contractors and consultants 8%, computer expenses 13% with other expenses (including medical and surgical supplies, pharmaceuticals, property expenses, etc.) adding around 7%.

The average cost per service, as shown in Table 19, is the full cost divided by the number of services, where the cost must include the initial set up cost of the service. The impact of this cost depends on the period over which it is amortised (i.e. whether all the value of the set up is in some way “used up” over 5 years/10 years/some other period, and the interest rate applied (this can be thought of as if the set up was paid for by a mortgage type loan, where repayments depend on the interest rate and the repayment period).

If we assume a 5% interest rate and a 10 year repayment, the set up costs are \$400,000 per year across those 10 years. Clearly higher interest rates or shorter repayment periods would add to this cost (and vice versa).

The number of services for the purposes of this analysis is the number Inbound (i.e. the number actually treated). Those Outbound are assumed initially to be directed somewhere appropriate, but to have no positive or negative effect (although the costs of redirecting them must be absorbed by Walk-in Centre). Alternate views are addressed in Appendix D.

Table 19: Average costs per Walk-in Centre service<sup>11</sup>

<b>Costs per service for the Walk-in Centre</b>	
<b>Period 18 May 2010 to 17 May 2011</b>	
Inbound patients	14,688
<b>Costs</b>	<b>(\$,000)</b>
Full year budget*	2,528
Actual expenditure‡	2,140
Plus 16% overheads	342
Amortised set up	400
Total costs (actual)	2,883
<b>Costs per service</b>	<b>\$196</b>

\* Budget for 2010-2011 financial year

‡ Note that the actual expenditure is below the level the full year budget

The average cost of a Walk-in Centre service including all fixed costs and set up costs is \$196. Marginal costs (as shown in Table 20) would be mainly staff costs plus add-ons. Costs such as computer costs are independent of volume. It is not clear if contractor costs are independent of volume but the following Table assumes that this is the case.

Table 20: Marginal costs per Walk-in Centre service

<b>Marginal costs per service for the Walk-in Centre</b>	
<b>Period 18 May 2010 to 17 May 2011</b>	
Inbound patients	14,688
<b>Costs</b>	<b>(\$,000)</b>
Full year budget*	2,528
Actual expenditure	2,140
Net contractor/computer costs	-390
Plus 16% overheads	280
Total costs (actual)	2,030
<b>Marginal Cost per service</b>	<b>\$138</b>

\* Budget for 2010-2011 financial year

### Costs of GP and ED treatment

ED costs have been taken from the National Hospital Costs Data Collection, Cost Report Round 13 (2008-09). These show national average costs for Triage 4 and 5 category patients of \$343 and \$221 respectively. Adjusting for the ACT cost weight relative to the national figure, and allowing for the relative numbers of each Triage group in normal ED activity and for inflation over two years, gives an overall average of \$281 per service. If the view is taken that the Walk-in Centre flow-on to ED is predominantly Triage category 5 this cost will be overstated, although the general patterns in Tables 17 and 18 will remain unchanged.

GP costs depend on the perspective taken, and the assumption about the length of consultation. If the ACT Health perspective is taken the cost of GP services are nil. If an all-

<sup>11</sup> Note that both average and marginal costs are higher than in the previous version of this costing due to an error in the previous version. When the error is corrected, the averages change little with the additional 6 months data.

of-government health perspective is taken costs are the MBS costs, and if a health system perspective is taken costs are MBS costs plus patient costs.

The national average fee charged per service and benefit paid per service provided by GPs in the December quarter 2010 were \$45.42 and \$40.41 respectively (this includes attendance items but excludes enhanced primary care items and nurse items). It is unclear whether patients take more or less complex conditions to the Walk-in Centre than those they take to GPs, so use of an overall average is an appropriate start point for analysis. As the difference between the government perspective and the health system perspective on GP costs is only \$5 per service, further analysis uses the higher cost only. Note that these are national figures as State level data are not available for average fees charged by GPs in the standard publicly available data sets.

### Costing time-frame

This analysis is based on the first twelve months of operation of the Walk-in Centre, and while the patterns of expenditure and service use have stabilised over that time, it would be expected in the longer term that the direct costs are likely to increase to the full budgeted amounts and that the number of services per day is also likely to increase. The structure of the service pattern may also change as Walk-in Centre becomes better known.

Walk-in Centre is notionally funded to provide 80 services per day. If this target was met for 365 days a year this would lead to 29,200 services per year (roughly the Walk-in Centre the level of services provided in the first year of operation). Full year costs are budgeted at \$2.528m, which with overheads and amortised set up costs leads to an average cost per service of \$114 which is well below the \$196 figure (due to the very much larger service volume). Similarly the marginal costs per service would be reduced from \$138 to \$79, which is still well above the average cost per service of general practice.

Given the service patterns observed to date, with lower demand on weekends and higher on Mondays, it seems unlikely that an average of 80 services per day will be reached in the immediate future. However this analysis provides a view of the extreme values of the simple costs of the Walk-in Centre.

## DETAILED ANALYSIS OF FLOWS

### The impact of the Walk-in Centre on flows through ED/GPs

As noted above, the following sections attempt to apply costs to changes in the flow of patients through the health system caused by Walk-in Centre, including additions to and subtractions from flows into general practice and the emergency departments. These sections are relevant only if either the wider health system perspective is taken (the GP costs) or notional ED costs are considered relevant. If these perspectives are not of concern the following sections are not relevant.

As discussed in the paper on Emergency Department flows, this is complex as, for example:

- > Numbers differ between reports and data extracts;
- > Patients who are “redirected to the ED” after treatment may have one less ED visit than would otherwise be the case, or may have more ED visits than would otherwise be the case;
- > Nearly half of Outbound patients are redirected to the ED, but there is no information on how many of them would otherwise have gone to the ED (or the GP) in the absence of Walk-in Centre;
- > While data is available on how many Inbound patients state they would otherwise have gone to the ED, the veracity of this data cannot be tested;

- > Further, it is necessary to make assumptions about the actual alternatives for those who stated they only considered attending Walk-in Centre;
- > While patients redirected to GPs are known, whether these patients add to community costs or simply cause deferral of other appointments is not known;
- > While it is known where patients were redirected or referred, it is not in general known if they took this advice.

Further complications arise due to differing perspectives and data logic. Table 21 shows the potential patient flows with and without the Walk-in Centre. Inbound patients are asked on arrival where they would have gone had they not gone to the Walk-in Centre. The majority report that they would have gone to their GP, a smaller number to the Emergency Department, and a smaller number again would either have done nothing about the problem or sought advice from a range of sources including their pharmacy, other allied health providers, or friends and relations. Another group, comprising 26% of consultations, said that they planned only to go to the Walk-in Centre so assumptions need to be made on how to deal with this group.

Patients treated at the Walk-in Centre are classified as “Treated” or “Redirected” (redirection follows treatment in the Walk-in Centre and relates to further care) with redirection sometimes because the Walk-in Centre was unable to provide complete care (e.g. because of its limited formulary or limitations on the range of conditions it can address), sometimes because the condition is ongoing and while the Walk-in Centre treatment is appropriate more treatment will be needed over time (e.g. for wound management). Judgments are therefore needed regarding the degree to which redirection implies more or less services provided overall.

Redirection to “other” services tend to be quite specialized – referrals to dentists or to specialty sections of the hospital for very targeted services. In the following we assume that patients would have been sent to these specialty areas regardless of whether the initial assessment was in the ED, by a GP or at the Walk-in Centre.

**Table 21: Patient flows with and without the Walk-in Centre: Inbound patients only**

**Data for 18 May 2010 to end May 2011**

Where patient redirected after treatment/assessment	Where patient report they would have gone in absence of Walk-in Centre			
	GP	ED	Walk-in Centre/None recorded*	Other†
GP	1,866	384	1,060	120
ED	228	217	153	23
Other	16	14	15	2
No redirection – treatment complete	4,837	1,489	4,082	476
Total	6,947	2,104	5,310	621
Percent of total	46.4%	14.0%	35.4%	4.1%

†Other includes Call healthdirect, Home/Selfcare, Non-professional advice, Pharmacy

\* Table changed from previous version as recording of “Walk-in Centre” intention and “None Recorded” appears to have changed radically between time periods. Percentages of other categories is little changed between versions.



### *Inbound patients who would have gone to Emergency Departments in the absence of the Walk-in Centre*

If we look at those who would have gone to the ED (and taking the intention at face value):

- > If there is no redirection and the treatment is complete we can estimate reduced ED activity and average net savings (as Walk-in Centre is less costly per service than ED)
- > Those redirected to other services (mental health, ante-natal, specialist registrars, dentists) we assume would have been redirected there post ED and these can also be treated as net reductions to ED and net savings with no adjustment for the other services
  - Net effect on volumes and costs is therefore the same as for complete treatment in Walk-in Centre
- > Those redirected to GPs for follow up will be a mixture of
  - patients for whom follow up is necessary and would have been necessary had the patient first attended ED (e.g. for continuous wound management after initial treatment, for follow up of infections);
    - for these patients there is a saving of one ED visit and the number of GP visits is unchanged
  - Patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre – in particular antibiotics);
    - For these patients there is a saving of one ED visit but an addition of one GP visit which would not have been required if the patients had attended ED
- > Those redirected to ED for follow up will also be a mixture of
  - patients for whom follow up is necessary and would have been even had the patient initially attended ED (e.g. for wound management after initial treatment, for follow up of infections)
    - For these patients there is a saving of one ED visit and the number of later ED visits is unchanged
  - Patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre)
    - For these patients there is no saving ED in visits
  - Patients requiring x-ray or other radiology on the weekend or after hours when the standard radiology unit is not available.
    - For these patients there is no saving of ED visits
    - It is assumed that radiology costs are the same wherever the referral came from. While costs will be broadly the same, referral from GPs would most likely be to private rather than public radiology. No allowance is made for this differentiation.

Examination of the reasons for care of those redirected to ED show a wide range. While the largest group is problems of injury and trauma, abdominal and chest problems also rank highly. There is a somewhat higher proportion of redirection on weekends and after hours but the differences are not large.

The pathways for patients who would have gone to the ED in the absence of the Walk-in Centre are summarized in Table 22 below.

Table 22: Potential service and cost implications for patients who would otherwise have gone to the ED

	Patient would have gone to ED without the Walk-in Centre		
Where patient redirected after treatment/assessment	Patient pathway	Impact on ED and GPs activity	Impact on ED and GP costs
GP	Need follow up and would have been referred on from ED	Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)
	Cannot be fully treated in Walk-in Centre and need GP additionally	Net reduction in ED activity Net additional GP activity	Net reduction in costs (as GP plus Walk-in Centre still lower cost than ED)
ED	Follow up is needed and would have needed a second ED visit	Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)
	Walk-in Centre cannot fully treat and need ED additionally	No net reduction in ED activity	Additional cost of Walk-in Centre with no offset
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	No net reduction in ED activity	Additional cost of Walk-in Centre with no offset
Redirection to “other” service or No redirection – treatment complete		Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)

While the impact on activity and costs in each of these categories can be estimated, the relative size of, for example, GP referrals which were inevitable and those which were additional, is simply not known. In the absence of better information, for calculation purposes we will use 50/50 split for this estimation and as relatively few of the ED group will be redirected for radiology this category was allocated 10% with 45% to the two other categories.

The calculation of the costs in these various categories depends on perspective as discussed earlier. The result if both GP costs and ED costs are considered is shown at Appendix E and summarized in Table 23. This shows that if all these factors are incorporated and costed, there is a net saving from reduced ED activity. This would not be the case if ACT Health perspective was taken with no ED costing as the various reductions in activity shown above would not lead to financial savings.

Appendix H summarises the outcomes from the perspective shown here including all costs, and from perspectives which assume no ED costs or no GP costs.



**Table 23: Summary of costs of patients planning to go to ED, incorporating ED and GP costs**

<b>Overall impact</b>	<b>Net cost per service</b>	<b>Proportion</b>
Redirect to GP	-\$63	18.25%
Redirect to ED	\$70	10.31%
Redirect to "other" or complete	-\$85	71.44%
<b>Total</b>	<b>-\$65</b>	

*Note: assumes Inbound patient views on where they would have gone in the absence of Walk-in Centre, and ignores Outbound patients*

***Would have gone to General Practitioner in the absence of the Walk-in Centre***

We look now at those who would have gone to their GP in the absence of the Walk-in Centre (again taking the intention at face value):

- > If there is no redirection and the treatment is complete we can estimate reduced GP activity and average net costs (as Walk-in Centre is more costly per service than GP )
- > Those redirected to other services (mental health, ante-natal, specialist registrars, dentists) we assume would have been redirected there by their GP in any case, and these can also be treated as net reductions to GP with no adjustment for the other services
  - Net effect on volumes and costs is therefore the same as for completed treatment in Walk-in Centre
- > Those redirected to GPs for follow up will be a mixture of
  - patients for whom follow up is necessary and would have been necessary had the patient first attended GP (e.g. for wound management after initial treatment, for follow up of infections)
    - for these patients there is a saving of one GP visit (with the number of ongoing GP visits assumed unchanged)
  - Patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre – in particular antibiotics)
    - For these patients there is no saving nor addition to the overall number of GP visits, and hence the net cost is the cost of the Walk-in Centre visit
- > Those redirected to ED for follow up will also be a mixture of
  - patients for whom follow up ED service is necessary and would have been had the patient first attended ED
    - for these patients there is a saving of one GP visit and the number of later ED visits is unchanged
  - Patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre)
    - For these patients there is a saving of a GP visit but the addition of an ED visit
  - Patients requiring x-ray or other radiology on the weekend or after hours when the standard radiology unit is not available.
    - For these patients there is again the saving of a GP visit but an additional ED visit
    - It is assumed that radiology costs are the same wherever the referral came from. While costs will be broadly the same, referral from GPs

would most likely be to private rather than public radiology. No allowance is made for this differentiation.

The pathways for patients who would have gone to their GP in the absence of the Walk-in Centre are summarized in Table 24 below.

**Table 24: Potential service and cost implications for patients who would otherwise have gone to the ED**

	<b>Patient would have gone to GP without the Walk-in Centre</b>		
<b>Where patient redirected after treatment/assessment</b>	<b>Patient pathway</b>	<b>Impact on ED and GPs activity</b>	<b>Impact on ED and GP costs</b>
GP	Need follow up and would have revisited GP	Net reduction in GP activity	Net reduction in overall costs
	Cannot be fully treated in Walk-in Centre and need GP additionally	No change in GP activity	No change
ED	Follow up is needed and would have been sent to ED by GP	Net reduction in GP activity	Net reduction in overall costs
	Walk-in Centre cannot fully treat and need ED additionally	Net addition to ED activity	Additional cost of ED with reduction in GP costs
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	Net addition to ED activity	Additional cost of ED with reduced GP costs - potentially reduced private radiology but assumed offset by public radiology costs
Redirection to "other" service or No redirection – treatment complete	Assume any other service would have been required in any case	Net reduction in GP activity	Net reduction in overall costs

While the impact on activity and costs in each of these categories can be estimated, the relative number of, for example, GP referrals which were made for follow up and those which were made to complete the initial consultation service, is simply not known. In the absence of better information, for calculation purposes we will use 50/50 split for this estimation. As there is relatively little referral to ED for radiology, this is assumed to be 10% of ED referrals, with the remainder split 45/45.

The calculation of the costs in these various categories depends on perspective as discussed earlier. The result if both GP costs and ED costs are considered is shown at Appendix F and summarised in Table 25. This shows that if all these factors are incorporated and costed, there is a net cost despite the reduced GP activity as GP unit costs are less than Walk-in Centre unit costs.

Appendix H summarises the outcomes from the perspective shown here including all costs, and from perspectives which assume no ED costs or no GP costs.

**Table 25: Summary of costs of patients planning to go to their GP, incorporating ED and GP costs**

<b>Overall impact</b>	<b>Net cost per service</b>	<b>Proportion</b>
Redirect to GP	\$174	26.86%
Redirect to ED	\$306	3.28%
Redirect to other or complete	\$151	69.86%
<b>Total</b>	<b>\$162</b>	

*Note: assumes Inbound patient views on where they would have gone in the absence of Walk-in Centre, and ignores Outbound patients*

### *Would have gone to an “Other” source of information in the absence of the Walk-in Centre*

We look now at the pathways for those patients who would have either waited for their condition to resolve and not sought care without the Walk-in Centre, or who would have sought advice from a friend or relation or from another health worker (e.g. a pharmacist). For this group almost by definition there are additional Walk-in Centre costs and potentially other costs, but no measurable savings. On the other hand this is the group which would otherwise not have had access to formal medical care, and so the potential clinical gains are the greatest.

- > If there is no redirection and the treatment was completed in the Walk-in Centre the cost is the cost of the Walk-in Centre service
- > Those redirected to other services (mental health, ante-natal, specialist registrars, dentists) we assume would have found their way in due course there in any case – this may be an understatement of costs
  - Net effect on volumes and costs is therefore the same as for complete treatment in Walk-in Centre
- > Those redirected to GPs for follow up will be a mixture of
  - patients for whom follow up is necessary as the condition requires more than one treatment, and patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre – in particular antibiotics)
  - for both of these groups of patients there is both a Walk-in Centre cost and a GP cost which would otherwise not have been paid
- > Those redirected to ED for follow up will also be a mixture of
  - patients for whom follow up ED service is necessary as the condition cannot be addressed in a single visit, and
  - patients who cannot be fully treated in the Walk-in Centre (mostly due to the restricted range of pharmaceuticals available at the Walk-in Centre)
    - For these patients as well as Walk-in Centre costs there is the additional cost of an ED visit
  - Patients requiring x-ray or other radiology on the weekend or after hours when the standard radiology unit is not available.
    - For these patients there is again an additional ED visit
    - It is assumed that radiology costs are the same wherever the referral came from. While costs will be broadly the same, referral from GPs would most likely be to private rather than public radiology. No allowance is made for this differentiation at this stage of the analysis.

The pathways for patients who would have sought “other” advice in the absence of the Walk-in Centre are summarized in Table 26 below.

While the impact on activity and costs in each of these categories can be estimated, the relative number of, for example, GP referrals which were made for follow up and those which were made to complete the initial consultation service, is simply not known. In the absence of better information, for calculation purposes we will use 50/50 split for this estimation. As there is relatively little referral to ED for radiology, this is assumed to be 10% of ED referrals, with the remainder split 60/30 on the assumption that the majority of those sent to ED have problems serious enough that they would eventually have attended in any case.

The calculation of the costs in these various categories depends on perspective as discussed earlier. The result if both GP costs and ED costs are considered is shown at Appendix G and summarized in Table 27. This shows that if all these factors are incorporated and costed, there is a net saving from reduced ED activity.

Appendix H summarises the outcomes from the perspective shown here including all costs, and from perspectives which assume no ED costs or no GP costs.

**Table 26: Potential service and cost implications for patients who would otherwise have sought advice from “Other” sources**

	<b>Patient would have gone to "Other" without the Walk-in Centre</b>		
<b>Where patient redirected after treatment/assessment</b>	<b>Patient pathway</b>	<b>Impact on ED and GPs activity</b>	<b>Impact on ED and GP costs</b>
GP	Need follow up and would have attended GP eventually in any case	No change in GP activity	No change in GP costs
	Would probably not have attended GP and waited to get better	Additional GP visit	No change
ED	Need follow up and would have attended ED eventually in any case	No change to ED activity	No change
	Would probably not have attended ED and waited to get better	Net addition to ED activity	Additional cost of Walk-in Centre and ED
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	Net addition to ED activity	Additional cost of Walk-in Centre and ED
Redirection to “other” service or No redirection – treatment complete	Assume any other service would have been required in any case	Nil	Nil

**Table 27: Summary of costs of patients who would otherwise have sought “other” advice, incorporating ED and GP costs**

<b>Overall impact</b>	<b>Net cost per service</b>	<b>Proportion</b>
Redirect to GP	\$219	19.32%
Redirect to ED	\$308	3.70%
Redirect to other or complete	\$196	76.97%
<b>Total</b>	<b>\$205</b>	

*Note: assumes Inbound patient views on where they would have gone in the absence of Walk-in Centre, and ignores Outbound patients*

#### ***Did not consider going to service other than the Walk-in Centre***

While data is available on the outcomes of attending the Walk-in Centre for this group, it is not possible to estimate net effects with no information on what their alternate patterns would have been. This group is therefore assumed to behave as the average of the other three groups (initial intent to visit a GP, visit ED, or take other action). If in reality all of this group would have simply waited to get better then this assumption is clearly an undercosting, but in the absence of other data it appears the most appropriate approach.

#### **Additional People Served and additional services**

As shown in Table 18, depending on the perspective taken the average cost per service at the Walk-in Centre after allowing for the flow on costs and savings ranges from \$115 to \$196 (assuming Inbound patient views on where they would have gone in the absence of Walk-in Centre are valid, and ignoring Outbound patients).

There are of course always different ways to approach this analysis. As mentioned in Section 5 c), the people who would not have otherwise have attended a GP or ED in the first instance have now been provided a service, so if we consider the objective of the Walk-in Centre in terms of additional access, we can consider the outcome of the Walk-in Centre the number of people who have been served who would not otherwise have received a medical service.

Over the first year of operation of the Walk-in Centre, around 36% of people treated stated their initial inclination was to seek other advice or to go to the Walk-in Centre. If all these visits were taken as people who would not have sought formal medical assistance otherwise it would mean 5,332 people who received a medical service in the period to end January where they would not otherwise have received such a service, while the other patients treated in Walk-in Centre would have gone elsewhere for treatment. This overstates the number of additional consultations as we do not know real alternative behaviour of those who said they would go the Walk-in Centre in any case.

If the overall impact of the Walk-in Centre was these 5,332 additional people being served at an additional cost to the ACT Health of \$2.883m, this would amount to \$540 per additional person serviced (excluding any flow on costs or savings to ED or general practice). This assumes of course that the other patients attending the Walk-in Centre who report they would otherwise have attended their GP (or ED) would have been able to do so, and would not have “bumped” somebody else off the lists of the GP or ED.

One factor omitted here, and which cannot be measured, is the eventual health cost of people who did not seek formal medical advice in the short term. Some of these (probably most of those with colds and other viral respiratory tract infections) would have recovered in time with no ill effects. Others would have eventually required medical assistance as their condition deteriorated and may have required far more significant medical care than required if they received timely care at the Walk-in Centre. The net impacts here are simply not knowable with the current data set.

A further factor which cannot be known is the degree to which the Walk-in Centre enables problems to be seen sooner and dealt with more expeditiously, both reducing pain and suffering for the patient and potentially addressing a condition before it deteriorates. Again unfortunately this is unknowable and cannot be included in any costing.

### Outbound patients

Outbound patients are those who on registration at the Walk-in Centre find that they are not eligible for services there because they do not fit Walk-in Centre's protocols. This is may be because children are aged under 2 years, or because the presenting conditions are outside the protocols. Outbound patients are advised to seek assistance elsewhere, and may be directed to ED, to their GP, or to some other health service provider as appropriate. The costs to Walk-in Centre of the outbound patients are the time spent by the reception staff and for some patients where the condition is not clear time spent (in the waiting room) by nursing staff to establish whether it is appropriate to treat the patient in Walk-in Centre.

The impact and costs of Outbound patients on other sectors are not clear. However, around 41% of Outbound patients are redirected to the TCH-ED. It is not known how many of these would have gone to the ED in the absence of Walk-in Centre, nor how many actually take the advice to attend Walk-in Centre. At one extreme it is possible that all of those who eventually went to the ED would have done so in any case, and the net effect on the ED is zero. At the other extreme it is possible that none of the Outbound patients would have otherwise come onto the hospital campus, and the total number Walk-in Centre referred on to the ED are additional ED patients. The calculations allowing for Outbound patients in Appendix D take these extreme positions to give a range of possible outcomes, as there is no information available to derive an alternate position.

### Discussion

The average cost of a Walk-in Centre service, however calculated, is less than the average cost of an emergency department service and greater than the average cost of a GP service.

The overall cost and cost per service of the activity of Walk-in Centre, however, depends on a large number of assumptions regarding the actual flow of patients, the flexibility of emergency department costing, and upon the perspective taken. The costs are also mainly based on the flow of work in the first twelve months of activity of Walk-in Centre, and with the passing of time as Walk-in Centre becomes more widely known in the community and as staff become more proficient with the computer based protocol systems the patient flow may increase more rapidly than staffing costs.<sup>12</sup>

Factors such as the flows of Outbound patients, the pathways which would have been taken by patients who declare that they had no other plan than to attend Walk-in Centre, the reasons patients were redirected following treatment all influence the estimated costs, as does the assumption that patients referred to "other" service providers generate no net costs from those providers. As shown in Appendix D, both average and total costs vary with the assumptions and perspectives, some very significantly.

In the absence of any ability to estimate clinical outcomes or outcomes in terms of quality of life the study has examined costs per service. This in effect assumes that the clinical benefits are the same for treatment by the Walk-in Centre as treatment by ED or general practice would have been for the same patients with the same conditions, which is a not unreasonable assumption.

Despite the sensitivity of the estimates to assumptions, the broad picture outlined in Tables 17 and 18 remains. Walk-in Centre is providing access to services to people who would not

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<sup>12</sup> The data hints that costs per service may be falling in 2011, but with lumpiness in major payments and different numbers of paydays per month it is difficult to confirm this pattern at this stage.

otherwise access these services. The average costs per service shown in Appendix D range from \$116 to \$196, which under any configuration are higher than average GP costs and lower than average ED costs. As general practitioners are not available the relative cost is not material, and the judgment to be made of whether the benefits of access are worth the costs is a more subjective question.

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## Appendix A

Table of final treatment status of patients by time of day arrived at Walk-in Centre: Inbound patients only

Final treatment status	Time of day arrived at Centre					Total (%)	Patients (N)
	Early (before 9am)	Morning (9am to 12noon)	Afternoon (Noon to 5pm)	Evening (5pm to 8pm)	Night (After 8pm)		
Treatment/information provided in WiC	62.9	62.5	62.3	64.7	63.2	62.9	9,240
Redirection to CALMS	0.3	0.8	1.0	4	2.8	1.6	231
Redirection to ED	4.6	4.6	5.1	5.7	8.5	5.4	786
Redirection to GP	20.3	20.5	20.7	18.2	18.3	19.9	2,929
Redirection to Medical Imaging	6.6	5.0	4.4	2.3	2.0	4.1	607
Redirection other	1.6	2.7	2.7	2.0	1.6	2.4	348
Patient did not wait	0.6	0.9	0.8	0.7	1.1	0.8	123
Other	3.2	3.0	3.0	2.5	2.7	2.9	424
Total (%)	100	100	100	100	100	100	
Total Patients (N)	1,281	3,934	5,481	2,575	1,417		14,688

# Appendix B

## ACT Health Walk-in Centre Nurse Satisfaction Interview Questions

- > Could you take me back to the beginning of your nursing career and tell me the story of how you came to work in the walk-in centre?
- > Can you tell me why you decided to work at the walk-in centre?
- > Tell me about your nursing role at the walk-in centre.
  - Is it different to previous nursing roles?
  - What and/or who has helped you to adapt to the new role?
  - Could the transition to the role been made easier in any way?
- > Tell me about the training and preparation you received for your work at the walk-in centre?
  - Do you believe the training was adequate?
  - How could it have been improved?  
What was the best aspect of the training?
  - What else would you like included in the training?
- > Tell me about the challenges of the job?
  - Is there variety?
  - What about the workload? Are you busy?
  - Do you have enough time to accomplish all that you would like to accomplish?
  - Do you have the resources you need to fulfil your role?
- > How is it working?
  - Can you see that you are keeping patients out of the emergency department or lessening the load for GPs?
  - Do you think you might be providing an additional service to the ED and general practice?
  - Do you think many of your patients would have managed their illness or injury at home if they had not attended the walk-in centre?
  - How would you compare the care you provide to that provided in the ED or by a GP?
- > How do you feel about the level of autonomy within your job?
- > How do you feel about the way your time is allocated?
- > What are sources of stress for you in your job?
- > Can you tell me about your relationships with patients?
  - Do you feel you have enough time to deliver quality nursing care?
  - Is there anything you would like to change if you could in regard to patient care?
  - Tell me about the feedback you receive? How do you know if the care you have provided is adequate or correct or if someone has got better?
- > Can you tell me about the Clinical Decision Support Software?
  - What works best about it?
  - What works least about it?
  - Is it supportive or constraining in terms of your capacity to provide care?
  - How would you change it if you could?
- > Tell me about the team at the centre?
  - Teamwork

- Co-worker interaction,
  - Cohesion and friendships in the immediate workplace
  - From where or whom do you gain support?
- > How does the roster work?
  - Do you work full-time?
  - Do you self-roster?
  - Is there flexibility in rostering?
  - Does working at the walk-in centre impact on your work-life balance?
- > Tell me about your relationship with your supervisor?
  - Do you have a lot of interaction with your supervisor?
  - Is it a supportive relationship?
  - Are there opportunities for you to contribute to the centre in terms of the way it operates?
  - Do you have educational opportunities within the workplace?
- > Tell me about your relationships with other health care providers?
  - Do you discuss patients with other providers?
  - Are they receptive to your professional opinions?
  - How do you respond to resistance from other providers?
- > So, what's next? Is there mobility/ flexibility for you within the walk-in centre?
- > So, on a finishing note, overall do you think the walk-in centre works?

# Appendix C

## ACT Health Walk-in Centre Stakeholder Interview Questions

### Physical facilities and equipment

- > Have you been to the Walk-in Centre?
  - Yes
  - No, next question
- > What was your experience of the centre?
- > How effective do you believe the layout of the centre is in terms of:
  - Patient flow
  - Safety for staff and patients (OH&S)
  - Privacy
  - Issues raised

### Processes of care provided

- > Can you tell me about your perception of the care provided at the Walk-in Centre?
  - Waiting time
  - Treatment time
  - Quality of care provided

### Service organisation and management, including protocols

#### *Model of Care, Risk management & Protocols*

- > What is your perception of the model of care (nurse-led) provided at the Walk-in Centre?
- > What is your perception of the clinical protocols utilised at the Walk-in Centre?
  - Do you consider clinical protocols to be a risk management strategy?

### Information systems

- > Have you, or your organisation, any experience of the information systems utilised at the Walk-in Centre?
  - For example, do you receive reports from the Walk-in Centre or printouts of information regarding patient care?
  - Have you had occasion to send information to the Walk-in Centre? If so, how effective was this process?

### Inter-provider agency networks, community networks and relationships

- > What is your perception of your organisation's relationship with the Walk-in Centre?
- > Do you believe the Walk-in Centre has had an impact on you, your organisation or the individuals your organisation represents? If so, what is that impact?
- > Has your organisation attempted to develop or change its relationship with the Walk-in Centre?
- > Has the Walk-in Centre implemented any processes to support a relationship with your organisation?

- > Has your organisation had any opportunities to have input into policy, planning and service delivery within the Walk-in Centre?
- > Would you like to change or have input into the operation of the Walk-in Centre?
- > What is your perception of the networks that have been developed between the Walk-in Centre and other health care providers?
  - e.g. Community health centres, Indigenous health centres, GPs, The Canberra Hospital emergency department, Outpatient clinics
- > Do you believe the Walk-in Centre has improved access to primary care for the ACT community?
- > How do you believe the community perceives the Walk-in Centre?
- > Do you believe the community has opportunity to influence policy, planning and service delivery within the Walk-in Centre?



## Appendix D

### Summary table with alternate assumptions regarding flow on to ED

	Assume: ALL those Inbound who said they would have gone to ED are correct, and  ALL Outbound sent to ED would have gone anyway		Assume : HALF OF those Inbound who said they would have gone to ED are correct, and  ALL Outbound sent to ED would have gone anyway		Assume: ALL those Inbound who said they would have gone to ED are correct, and  NONE of Outbound sent to ED would have gone otherwise†		Assume: HALF those Inbound who said they would have gone to ED are correct, and  NONE of Outbound sent to ED would have gone otherwise†	
Perspective	Cost per Walk-in Centre service	Net cost for June-Dec 2010	Cost per Walk-in Centre service	Net cost for June-Dec 2010	Cost per additional service (Walk-in Centre & ED)	Net cost for June-Dec 2010	Cost per additional service (Walk-in Centre & ED)	Net cost for June-Dec 2010
					<i>1320 additional treatments in ED</i>			
ACT Health perspective, assume <b>no change</b> in expenditure in ED	\$196.00	\$2.883	\$196.00	\$2.883	\$180	\$2.883	\$180	\$2.883
ACT Health perspective, assume changes in ED activity lead to <b>changes in costs</b>	\$142.32	\$2.090	\$170.38	\$2.503	\$154	\$2.461	\$180	\$2.874
Health perspective, assume <b>no change</b> in expenditure in ED*	\$169.17	\$2.485	\$165.06	\$2.424	\$155	\$2.485	\$151	\$2.424
Health perspective, assume changes in ED activity lead to <b>changes in costs</b>	\$115.50	\$1.696	\$139.45	\$2.048	\$129	\$2.067	\$151	\$2.419
* Although there are no ED costs assumed, overall costs vary slightly between hypotheses 1 and 2, and between hypotheses 3 and 4, because the changed assumptions about intent lead to changed flow ons to GPs/ED etc								
† Includes both ED costs and services								

## Appendix E

### Patients who would have gone to ED – Includes all costs

	Patient would have gone to ED without the Walk-in Centre							
Where patient redirected after treatment or assessment	Patient pathway	Impact on ED and GPs activity	Impact on ED and GP costs	Assumed Percent of category	Impact on ED and GPs activity	Impact on ED costs	Impact on GP costs	Average cost Including Walk-in Centre cost)
GP	Need follow up and would have been referred on from ED	Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)	50%	"-1 ED visit/ no change to GP visits	-281		-62.5
	Cannot be fully treated in Walk-in Centre and need GP additionally	Net reduction in ED activity Net additional GP activity	Net reduction in costs (as GP plus Walk-in Centre still lower cost than ED)	50%	"-1 ED visit/+1 GP visit	-281	45	
ED	Follow up is needed and would have needed a second ED visit	Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)	45%	"-1 ED visit	-281		69.6
	Walk-in Centre cannot fully treat and need ED additionally	No net reduction in ED activity	Additional cost of Walk-in Centre with no offset	45%	Nil			
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	No net reduction in ED activity	Additional cost of Walk-in Centre with no offset	10%	Nil			

Redirection to "other" service or No redirection – treatment complete	Assume any other service would have been required in any case	Net reduction in ED activity	Net reduction in overall costs (if costs applied to ED)			-281		-85
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Overall impact	Net cost	Proportion
Redirect to GP	-\$63	18.25%
Redirect to ED	\$70	10.31%
Redirect to other or complete	-\$85	71.44%
<b>Total</b>	<b>-\$65</b>	

## Appendix F

Patients who would have gone to their GP – Includes all costs

	Patient would have gone to GP without the Walk-in Centre							
Where patient redirected after treatment or assessment	Patient pathway	Impact on ED and GPs activity	Impact on ED and GP costs	Percent of category	Impact on ED and GPs activity	Impact on ED costs	Impact on GP costs	Average cost Including Walk-in Centre cost)
GP	Need follow up and would have revisited GP	Net reduction in GP activity	Net reduction in overall costs	50.0%	"-1 GP visit		-45	173.5
	Cannot be fully treated in Walk-in Centre and need GP additionally	No change in GP activity	No change	50.0%	"No change		0	
ED	Follow up is needed and would have been sent to ED by GP	Net reduction in GP activity	Net reduction in overall costs	45.0%	"-1 GP visit		-45	305.6
	Walk-in Centre cannot fully treat and need ED additionally	Net addition to ED activity	Additional cost of Walk-in Centre and ED with reduction in GP costs	45.0%	"-1 GP visit, +1 ED visit	281	-45	
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	Net addition to ED activity	Additional cost of Walk-in Centre and ED with reduced GP costs –no net radiology cost	10.0%	"-1 GP visit, +1 ED visit	281	-45	
Redirection to "other" service or No redirection – treatment complete	Assume any other service would have been required in any case	Net reduction in GP activity	Net reduction in overall costs				-45	151

<b>Overall impact</b>	<b>Net cost</b>	<b>Proportion</b>
Redirect to GP	\$174	26.86%
Redirect to ED	\$306	3.28%
Redirect to other or complete	\$151	69.86%
<b>Total</b>	<b>\$162</b>	

## Appendix G

Patients who would have gone to "Other" source of information– Includes all costs

	Patient would have gone to "Other" without the Walk-in Centre			Assume no clinical costs of "other"				
Where patient redirected after treatment or assessment	Patient pathway	Impact on ED and GPs activity	Impact on ED and GP costs	Percent of category	Impact on ED and GPs activity	Impact on ED costs	Impact on GP costs	Average cost Including Walk-in Centre cost)
GP	Need follow up and would have attended GP eventually	No change in GP activity	No change in GP costs	50.0%	0		0	218.5
	Would probably not have attended GP and waited to get better	Additional GP visit	No change	50.0%	"+1 GP visit		45	
ED	Need follow up and would have attended ED eventually in any case	No change to ED activity	No change	60.0%				308.4
	Would probably not have attended ED and waited to get better	Net addition to ED activity	Additional cost of Walk-in Centre and ED	30.0%	"+1 ED visit	281		
	After hours Walk-in Centre cannot refer to radiology and need to go through ED	Net addition to ED activity	Additional cost of Walk-in Centre and ED	10.0%	"+1 ED visit	281		
Redirection to "other" service or No redirection – treatment complete	Assume any other service would have been required in any case	Nil	Nil					196

<b>Overall impact</b>	<b>Net cost</b>	<b>Proportion</b>
Redirect to GP	\$219	19.32%
Redirect to ED	\$308	3.70%
Redirect to other or complete	\$196	76.97%
<b>Total</b>	<b>\$205</b>	

## Appendix H

### Summary of calculations and revised calculations for different perspectives

#### Summary

View 1: ACT Health perspective, assume no change in expenditure in ED

Net cost per Walk-in Centre service \$196

Total additional costs over the first year of operation of \$2.883m

View 2: Overall Health perspective, assume changes in ED activity lead to changes in costs

Those who would have:	Average net cost of each service	Proportion in each category
Gone to GP	\$162	48.30%
Gone to ED	(\$65)	14.60%
Gone to other	\$205	4.30%
Only thought of Walk-in Centre	\$115	32.80%
<b>Total</b>	<b>\$115</b>	

Total additional costs over the first year of operation of \$1.696m

View 3: Overall Health perspective, assume changes in ED activity lead to no changes in costs

Those who would have:	Average net cost of each service	Proportion in each category
Gone to GP	\$157	48.30%
Gone to ED	\$200	14.60%
Gone to other	\$200	4.30%
Only thought of Walk-in Centre	\$169	32.80%
<b>Total</b>	<b>\$169</b>	

Total additional costs over the first year of operation of \$2.485m

View 4: ACT Health perspective, assume changes in ED activity lead to changes in costs

Those who would have:	Average net cost of each service	Proportion in each category
Gone to GP	\$201	48.30%
Gone to ED	(\$69)	14.60%
Gone to other	\$200	4.30%
Only thought of Walk-in Centre	\$142	32.80%
<b>Total</b>	<b>\$142</b>	

Total additional costs over first year of operation of \$2.090m



# Appendix J

## ACT Health Walk-in Centre Clinical Advisory Group

### Terms of Reference:

Review and / or recommend changes to:

- > Key Performance Indicators
- > Risk management
- > Adverse events
- > Clinical policy, protocol or medication standing orders
- > Occupational Health and Safety
- > Quality Assurance Projects and Accreditation

### Membership:

- > Director of Nursing, Ambulatory Care & Medical Services, The Canberra Hospital (TCH)
- > Medical Director, Hospital in the Home, TCH
- > ACT Ambulance Service nominee
- > GP Liaison, TCH
- > GP Advisor, ACT Health
- > Consumer Nominee
- > Director of Nursing, Access & Logistics, TCH
- > Director Acute Support, TCH
- > General Manager, Community Health, ACT Health
- > Community Health Continuing Care Program, Nursing Services Manager, ACT Health
- > TCH Physiotherapy Representative
- > TCH Pharmacy Representative
- > Access Improvement Program Project Manager, ACT Health
- > Australian Medical Association (AMA) (declined ACT Health invitation to appoint a nominee)
- > ACT Division of General Practice (ACTDGP) (declined ACT Health invitation to appoint a nominee)

# Appendix K

## Reference Group

### Membership

Ian Thompson, ACT Health

Tanya Robertson, GP Advisor to The Canberra Hospital

Marion Reilly, Health Care Consumer Association

Debbie Hagen, Rehabilitation Nurse Practitioner, ACT Health

Shane Lenson, Royal College of Nursing Australia

Kelsy Hegarty, University of Melbourne

Rhian Parker, Australian Primary Health Care Research Institute (APHCRI)

### Observers:

Veronica Croome, ACT Chief Nurse

Laura Forrest, APHCRI

Ian McRae, APHCRI

Jane Desborough, ACT Health/APHCRI

### Schedule of meetings:

- > Wednesday, 27 October, 2010
- > 2 February, 2011, 5.30 p.m.
- > 5 April, 2011, 5.30 p.m.
- > 7 June, 2011, 5.30 p.m.