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CHARTING NEW ROLES FOR AUSTRALIAN GENERAL PRACTICE NURSES: A MULTICENTRE QUALITATIVE STUDY

Phillips CB, Pearce CM, Dwan KM, Hall S, Porritt J, Yates R, Kljakovic M, Sibbald B

POLICY CONTEXT

General practice in Australia is undergoing a period of intense change. There is an emerging policy focus on nurses as deliverers of primary care services funded through Medicare, although the public discourse about this is largely couched as a debate about substitution of service delivery, rather than innovation in primary care. During the time of this study, the number of practice nurses employed in Australian general practices rose from just under 5000 to nearly 8000, and there is steadily increasing recognition of the contribution nurses can make in this context. Despite this growing support there have been some interprofessional tensions in response to proposed changes and some medical organisations have mounted a case that team models of primary health care are rendered unsafe if the GP is not the leader of the team.

Until now, there has been little systematic research addressing the roles of Australian general practice nurses, the determinants of these roles and ways of driving change in general practices to improve teamwork between GPs and nurses.

KEY FINDINGS

OPERATING ROLES

Nurses have six key operating roles oriented towards patients, the practice itself and the community. These operating roles extend beyond the clinical and administrative roles which are generally understood to be part of nurses' work, and are:

- Nurse as patient carer
- Nurse as quality controller
- Nurse as organiser
- Nurse as problem solver
- Nurse as educator
- Nurse as agent of connectivity.

The patient carer, organiser and quality controller roles are well-recognised by doctors and managers in practice, but the roles of educator, problem solver and agent of connectivity tend to be under-estimated and are unfunded. Nurses play a key role in creating resilient general practices, through their capacity to cycle rapidly through these six operating roles and their particular function

around connectivity – where they are able to act as a bridge between all staff within the general practice, and between the practice and patients in the community.

In contrast to doctors' work in general practice, nurses' work is relatively unstructured and they are highly reactive to the needs of others. Because of this, they tend to make practices more accessible to patients and are especially useful in ensuring continuity of care across doctors and in outreach when patients are in the community.

ROLE DETERMINANTS

Factors influencing role operate at three levels.

- Structural determinants highlighted in this work are (a) health care funding for nurses which has increased the absorption of nurses into general practice policy, but now needs expansion so that the clinical roles are not constrained; (b) professional culture which highlights for nurses the affective dimension of patient care and a systems focus.
- Practice-level determinants are primarily the physical structure of the practice, time-use patterns, and the nature of interprofessional relationships. The location of the nurse in places of transition for other staff tends to support the connectivity role. The unhappiest nurses in this study had segregated quarters where they did not have intercurrent contact with patients or doctors.
- Individual determinants include knowledge, skills, attitudes and professional identity. Key factors here are often experience and community standing. Rural nurses, in particular, are often women with considerable local standing and organisational skill, and they bring this to their role. Nurses in this study often had high levels of skills and experience through working across many health and non-health sectors, which was often underused in general practice. Many GPs are unaware of the range of work done by nurses in their practices.

NURSING CONTRIBUTION TO QUALITY & SAFETY

Nurses combine structured quality improvement activities like accreditation with more patient-centred, subjective caring activities. Elements that support quality care by nurses include: being able to access all parts of the general practice; being centrally located within the practice; being invested with continuity of personal care, especially when many doctors worked part-time; and having relative freedom over disposal decisions about their time.

NEW MODELS OF PRACTICE NURSING

Most of the innovations introduced into the research practices were small, but at 12 month follow-up, the knock-on effects in most practices had been substantial with enhancement of the nurse role and greater cohesion in the general practice unit. Successful changes tend to result in organisational change, which then drives changes to interprofessional working. Key to the introduction of the innovations was the existence of structured external support and networking between practices.

POLICY OPTIONS

To date, policy-making in this area has been pragmatic and effective. By beginning with a program of small-scale funding of work identifiably in the nursing domain (wound management, immunisation), and gradually supporting initiatives that promote teamwork and systematised chronic disease management, policy-makers have charted a course which offered the most feasible way of promoting and expanding practice nursing without alienating key stakeholders. There is a need now to expand the work of nurses in ways which capitalises on the specific skills of nurses, and to address barriers to the further expansion of nursing in general practice. Failure to do this may result in attrition of nurses from general practice

ENHANCING CLINICAL CARE BY NURSES

While the business case for nurse employment in general practice is well established, incremental additions will be important in developing the innovative potential of team based care. These should

be progressively more flexible and less structured to prevent an unhelpful focus on task substitution and facilitate interdisciplinary practice. Important next steps may be:

- Funding to support preventive care either through Medicare or through other funding channels – focusing particularly on management of obesity and lifestyle diseases
- Developing alternative approaches to perceived and ongoing conflicts regarding professional indemnity for nurses. This may be a small change which could have large effects in terms of role enhancement.

ENHANCING THE EDUCATOR ROLE

Nurses already function as de facto educators within the general practice of other staff, especially GP registrars and other nurses. Opportunities to formally recognize and empower nurses as educators in the interdisciplinary setting include:

- (undergraduate) student preceptorship
- prevocational and vocational training support for GPs and nurses in training
- continuing education for medical, nursing and allied health colleagues.

ENHANCING RECRUITMENT, ENSURING RETENTION

Sustaining the general practice nursing workforce will be a major challenge for the future, in the light of health workforce shortages. Issues to be considered should include:

- National uniformity around salary structure
- Career path, including progression to nurse practitioner status
- Professional development. The Divisions Network is a unique infrastructure element which can support this.
- Organisational development of general practices including employer training obligations.

ENHANCING PHYSICAL INFRASTRUCTURE FOR NURSES

Restrictions on space limit role scope and number of nurses. This is especially evident in urban practices where space is often a more limited commodity. Role optimization for nurses requires the availability of functional spaces. Enhancing the clinical work of nurses will require infrastructure funding to overcome business obstacles.

METHODS

This three year study commenced in 2005, and consisted of two sequential phases:

- a cross-sectional, multi-method, descriptive study of 25 general practices in south eastern Australia. The sampling frame included practices with varied locations, staff configurations and business structures. Practices were visited for one day by a trained researcher who utilized a rapid appraisal approach to conduct interviews (36 nurses, 24 GPs, 22 managers), participant observation (51 hours, 34 nurses), and collect photographs of workplaces (n=205), floorplans (n-25) and other documentary evidence
- a naturalistic long-term study of seven general practices in five states, exploring change as it occurred. Participants undertook to introduce a small scale change focused on the role of the nurse, with support from the local Division of General Practice. Key staff attended two workshops at the beginning and midway through the change process, and evolving documentation was collected as data. Culture mapping tools (practice genograms, development of visual archetypes) were used to develop a deeper understanding of barriers to change within the practice. Narrative interviews (n=32) were conducted during the project, and six months after completion. Each case study was analysed for project-level outcomes, and impacts on the role of the nurse and interprofessional working.

For more details, please go to the full report

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