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Practice nurses' perceptions of their contribution to the
care of individuals with chronic health conditions:
An exploratory descriptive study

A thesis submitted in partial fulfilment of the requirements of the degree
of
Master of Philosophy in Nursing

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ABSTRACT

The release of the New Zealand Primary Health Care (PHC) Strategy (King, 2001), placed an increased emphasis on the provision of healthcare in the community or primary health care setting, and in particular on the role of PHC nursing. Alongside this, new roles are being created which practice nurses are expected to fulfil such as 'Care Plus', which is an initiative of the PHC strategy providing funding for increased care of people with high needs due to chronic conditions or terminal illness. Practice nurses are health care providers in general practice settings, and it is assumed that they make a significant contribution to the health of individuals with chronic conditions. In this study an exploratory descriptive approach was used to explore practice nurses' perceptions of their contribution to the care of individuals with chronic conditions. The total number of participants was eleven.

Thematic content analysis was used to develop themes from the data. Overall practice nurses described three key areas of contribution: The preparation of the individual for an appointment at the general practice, care provided by the practice nurse at the general practice, and the giving of information. Each theme consisted of a considerable level of complex processes employed by the practice nurses, with all being inextricably interwoven within the care. A number of dualities were apparent that impact on the contribution practice nurses perceive they make to individuals with chronic conditions, within the reality of their practice contexts.

The systems within which the practice nurse participants described working posed certain challenges to the fulfilment of the role of registered nurse. Recommendations include the significance of the development and maintenance of nurse-client relationships, achieving a balance between the organisation provided by computerised systems and client centred care, and the concept of adequate time for interactions with individuals. Recommendations regarding nursing's role in acknowledgment of the individual as an active participant in care, the recognition of an individual's right of choice regarding ongoing contact with the general practice, and a need to recognise a focus of care as support of client self-management also arise from this study.

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KEY

The following key will assist you with interpretation of the transcript examples during the presentation of the findings:

...	Text removed
[bracketed words]	Words added by author to enhance meaning
<i>Italics</i>	Participant speech
<i>Bold italics</i>	Interviewer's speech
(bracketed words)	Text altered to remove identifiers
line -number	Line number of transcript
(female name, line number)	Participant pseudonym

Chapter 1

Background and overview

Introduction

The release of the New Zealand Primary Health Care Strategy (King, 2001) has placed an increased emphasis generally on the provision of healthcare in the community or primary health care setting, and in particular on the role of primary health care nursing. The Primary Health Care Strategy has six key directions including a specific objective around offering access to comprehensive services to restore, improve, and maintain people's health (King, 2001, pp.vii). Nurses are health care providers in a range of settings that include practice nurses in primary health care, and alongside this, New Zealand is experiencing increased numbers of people diagnosed and living with chronic health conditions (chronic conditions)(New Zealand Health Information Service [NZHIS], 2001). A chronic condition is a condition that has lasted, or is expected to last, more than six months (National Health Committee [NHC], 2005). The contribution that practice nurses in New Zealand make to the care of individuals with chronic conditions is not readily identifiable in research or literature.

This chapter outlines the researcher's interest in the topic, the study background, and aim. Included also is a background on practice nursing, encompassing historical and political development, employment and funding, and role description. Alongside this is an analysis of contemporary New Zealand health care strategies and the role of the practice nurse within these. To complete the chapter there is a discussion on the "living with" chronic conditions and the practice nurse role.

Study aim

The research question is:

What are the perceptions of practice nurses regarding their contribution to the care of individuals with chronic health conditions?

Researcher interest

My interest in this research originated from work as a practice nurse from 1990 to 2005. During this time, coupled with my involvement in governance roles as a practice nurse representative on both Independent Practice Association (IPA) and Primary Health Organisation (PHO) boards, I was aware of the increased emphasis being placed upon practice nurses as Primary Health Care (PHC) nurses.

In particular, I was interested in the increasing roles being created such as with 'Care Plus', an initiative of the PHC strategy providing funding for increased care of people with high needs due to chronic conditions or terminal illness (Ministry of Health, (MOH) 2005), which practice nurses were expected to fulfil. Due to my experience as a practice nurse, I was aware of the varying contexts and constraints that practice nurse colleagues were working within, and I felt it necessary to explore this further. At the commencement of the research the formation of PHOs was at an early stage in the geographical area, and I was particularly interested in the perceptions of practice nurses prior to the instigation of any new nursing roles in the care of individuals with chronic conditions.

Background

Practice nurses and the current context of Practice Nursing in New Zealand.

In New Zealand, practice nurses have provided nursing services in general practice for over fifty years. The role and scope of the practice nurse has developed, as has the direction from the government regarding health priorities. A practice nurse is a Registered Nurse who works with a general practitioner (GP) in a clinic setting (general practice) in the community, and this setting is located within a

framework of PHC in New Zealand health strategies. General practice can be organised as various structures to include private businesses (the majority situation), iwi providers (Maori health care providers), not-for-profit trusts, and those that provide after hours care (accident and medical centres).

Historical and political development

In the past ten years the majority of general practices in New Zealand have been structured as part of IPAs, with functions aimed at coordination of patient care, and contractual support to the individual practices. Many have held specific budgets such as for laboratory and pharmaceutical usage in their area. The IPAs historically were geographically aligned. In relation to practice nurses, a component of these structures has been the securing of contracts to provide additional services such as sexual and reproductive health, chronic condition case management (such as for mental health), and palliative care. These typically involved general practice teams, consisting of practice nurses and general practitioners, providing coordinated comprehensive care to identified individuals and their families. The IPAs have historically provided varying degrees of nursing leadership and support for the professional development of practice nurses through management and governance roles.

New Zealand Health Care Strategies and Practice Nursing

At a national level, in response to increasing numbers of individuals diagnosed and living with chronic conditions, the MOH has increased the emphasis on, and funding of, health care since 2000. The New Zealand Health Strategy (MOH, 2000), set out thirteen population health objectives, two focussing on the need to reduce the incidence and impact of cardiovascular disease and diabetes, and the remaining eleven focussed on the priority of healthy lifestyles and prevention of chronic conditions. Following this the release of the New Zealand Primary Health Care Strategy (King, 2001), placed an increased emphasis on the provision of healthcare in the community or primary health care setting, and in particular on the role of primary health care nursing. Practice nurses are health care providers in general practice settings, and it is assumed that they make a significant contribution to the health of individuals with chronic conditions. However, research on which to base this assumption is not readily identifiable in the current literature.

The central role of primary health care to the health of individuals and communities is further acknowledged by the PHC strategy. The vision, to be achieved over five to ten years, envisages people being part of local primary health care services that “improve their health, keep them well, are easy to get to and coordinate their ongoing care... and focus on population health actively working to reduce health inequalities between different groups (King, 2001, pp. vii). This is to be achieved through the organisation of services which are focussed on the needs of a defined group of people. Primary Health Organisations (PHOs) have been designed to achieve this, as not-for-profit provider organisations funded by District Health Boards (DHBs) to provide primary health care services to an enrolled population. Primary health care nursing is described as a key component to achieving the vision of the PHC strategy. Under the umbrella of a PHO it is planned that providers will be part of primary health care teams intended to work collaboratively to meet the health care needs of the enrolled population (King).

As an example of possible approaches at the District Health Board (DHB) level, MidCentral DHB published a Primary Health Care Strategy in 2004, which signalled an emphasis on the development of PHC teams to improve the management of healthcare for enrolled populations. The shape and size of these teams is described as needing to reflect the locality and characteristics of the teams enrolled population, cultural competencies relating to the enrolled population, relationships with other PHC teams, and the teams’ relationship with the PHO. Core members are likely to include any of the following: Allied health professionals, Dentists, General Practitioners, Maori health professionals, Nurse Practitioners and primary health care nurses (MidCentral District Health Board, 2004). Practice nurses are a group identified as primary health care nurses.

Currently GPs and practice nurses provide a significant amount of the health care services to the PHO enrolled population, and practice nurses are the single largest group of nurses working in PHC. Practice nurses, as with other PHC nurses are an increasingly aging workforce, with an average age of 47 years (MOH, 2003a).

Employment and funding

As at 2006, the practice nurse is commonly directly employed by the private business owner (often the GP). The government currently funds approximately 40% of the practice nurse salary; the remaining being funded through fee-for-service from the clients. This partial funding occurs within the PHO environment, whereby general practices as contracted providers to PHOs, qualify for a level of funding (capitation funding) toward the healthcare of their enrolled population based upon the ethnicity and age of the population (Cumming & Mays, 1999). The enrolled population refers to those individuals that are registered patients of a general practice contracted to the PHO to provide first point of contact primary care services.

Practice nurses may work in group practices with a number of GPs and nurses, or may work in a location where there are only two health professionals- a GP and a practice nurse. How the practice nurse role is determined varies, ranging from the provision of task-orientated care to the provision of nursing care to the entire enrolled population of patients (Horsburgh, Kent, & Coster, 2005).

Role description

A Practice nurse is a Registered Nurse whose main focus is the delivery of nursing services in the primary health care setting. Practice Nurses work with General Practitioners as integral members of the Primary Health Care team. It is recognised that their scope of practice may vary widely and may include health assessment, promotion, education and nursing services, alongside advocacy and liaison with other health professionals. Practice nursing is a primary health care service which provides care to those who present to the practice. There is not only a focus on maintaining the wellness of each individual, but also an emphasis on health promotion and the prevention or early detection of disease. This service should be available, appropriate, supportive and affordable. As a member of the Primary Health Care Team, the practice nurse is professionally accountable for all aspects of the delivery of nursing care and may assist as a coordinator of case management (New Zealand College of Practice Nurses, New Zealand Nurses Organisation, [COPN, NZNO] 2003a).

As such practice nurses are integral members of general practice services working with individuals and families that are registered with the practice. The practice nurse may undertake a variety of nursing and administrative roles, and these may reflect the philosophy of the employer such as the general practitioner. The role may include:

1. Promoting health with individuals and families, with an emphasis on wellness. Specifically this may include: immunisation, cervical screening, child/adolescent health checks, and well person health checks.
2. Health education, including the provision of ongoing education to individuals and families, teaching skills for health maintenance and prevention of accidents and illness. Specifically this may include: immunisation, travel medicine advice, health and lifestyle education
3. Assessment to include detailed history taking, telephone and physical triage, and collection of data for example; blood pressure recording, blood glucose measurements, weight, initial assessment of accidents and emergencies, and opportunistic assessment.
4. Nursing services which incorporate working effectively as a team member providing quality nursing care and ongoing support to patients. Examples include management of soft tissue injuries, wound care, communicating test results and reports to patients, and referral to and liaison with other health professionals and support agencies such as budget services and outreach immunisation services.
5. Clinical maintenance where practice nurses have a responsibility to maintain documentation and provide nursing management/maintenance, and advocacy. This includes documenting all nursing/patient contacts such as telephone and verbal advice. Recall systems to identify and target patients overdue for screening and interventions are included here.
6. Quality to encompass ongoing assessment of activities via quality assurance within the general practice. Specifically this is recommended to include monthly immunisation audits, cervical screening audits in conjunction with the National Cervical Screening Register, influenza vaccine uptake audits, and regular audits of recalls such as percentages of mammograms and cervical smears. Participation in regular nursing clinical meetings to review current practices, extend evidence-based practice and review recommendations to align practice accordingly, may also be undertaken.

7. Support and monitoring of clients with diagnosed chronic conditions such as conducting a regular review of people with hypertension, and cardiovascular disease. This regular review may consist of a comprehensive assessment of current health status to include a nursing assessment, signs and symptoms of disease, and medication assessment. Furthermore, lifestyle assessment, and risk factor assessment may be undertaken to include surveillance of any new risk factors and general dietary and lifestyle advice. Included here is smoking cessation advice and support.
8. Practice nurses may also work within an extended role to include case management of registered clients with diagnosed chronic conditions such as diabetes, asthma, and COPD. These may include regular clinical review by the practice nurse, and liaison with the GP. Also incorporated may be a comprehensive assessment to include assessment of self monitoring, medication review, lifestyle issues, social and psychological assessment, physical assessment to include vital signs, and recommendations communicated to other team members to include the individual/family/whanau, GP, and PHC providers outside of the general practice such as district nurses.
9. Support and mentoring of undergraduate nursing students on community placements within the general practice setting.
10. In larger group practices there may also be practice nurses fulfilling management roles, including management and coordination of the nursing team, initiation of regular nursing clinical meetings, advice and input into professional development and education initiatives of practice nurses, and consideration of new practice initiatives. These nurse managers would regularly liaise with GPs.

The range of the practice nurse role, as described, is informed by the personal experience of the researcher and is reflective of the Practice Nurse Job Description, provided by the national body for practice nursing in New Zealand (COPN, NZNO, 2003b).

Professional development and competence demonstration

All nurses, including practice nurses, have historically signed a declaration of competence for their Annual Practising Certificate. Since the introduction of the Health Practitioners Competence Assurance Act 2003, the Nursing Council of New Zealand (NCNZ) has begun randomly auditing the competence of five percent of registered nurses annually. For practice nurses, as with all registered nurses prior to 2006, there was no actual requirement to demonstrate competence to the NCNZ, however since 1998 there has been a voluntarily accreditation process available enabling practice nurses to undertake a demonstration of competence. In 2005 the COPN NZNO, submitted the accreditation process to NCNZ for approval of competence demonstration; this was successful. Practice nurses who have achieved the accreditation process are deemed competent, and are exempt from the NCNZ random audit process. The number of practice nurses whom have demonstrated competence through the accreditation process is not readily available to the researcher.

Ongoing education and professional development for practice nurses may be provided by a number of sources including local DHBs, IPAs, management support organisations (MSOs) to PHOs, tertiary institutes, and less commonly medical and pharmaceutical companies.

Living with chronic conditions and Practice Nursing

Increasing numbers of New Zealanders are diagnosed and live with chronic conditions. Of the most prevalent chronic health conditions in New Zealand, heart disease has a prevalence of 9.6% for men and 8.4% for women; Type 2 diabetes has a prevalence of 4.5% for men and 3.7% for women, and chronic obstructive respiratory disease 4.8% for males and 3.6% for females. The average prevalence of chronic health conditions is estimated to be 6% of the total population (NZHIS, 2001). Also of note, Maori and Pacific Island people are disproportionately affected (MOH, 2004). Chronic diseases contribute the major share of the growing disparity in life expectancy between Maori and Pacific, and non-Maori non-Pacific people (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). In 2001, 44% of male deaths and 47% of female deaths were attributed to cardiovascular disease, chronic respiratory disease and diabetes (NZHIS).

Approximately 6% of the New Zealand population live with a chronic condition, that affects their life and wellbeing. Living with a chronic condition or several conditions, can have a significant impact on peoples' lives, including family wellbeing and capacity to undertake fulfilling work and other activities (NHC, 2005).

Acute and chronic illnesses are differentiated by Holman and Lorig (2000). With acute illness, the treatment usually aims towards a return to normal functioning, whereas with chronic illness, the person's life is described as being irreversibly changed. With chronic conditions, neither they nor their consequences are static, and they interact to create continuous and complex health management. Variations in patterns of illness and treatments with uncertain outcomes create uncertainty about prognosis (Holman & Lorig). According to Snell and Boyd (2004) there has been an increase in hospital admissions in New Zealand since 1997 that could have been prevented with proper primary health care. These preventable hospital admissions include exacerbations of chronic illness and have increased by 2.5% for pakeha, 4.1% for Maori and 8.9% for people of Pacific Island extraction (MOH, 2001).

Sidorov et al. (2002) suggest the practice nurse may be the first point of contact for people with chronic conditions, where they may effectively provide expert nursing care based on a sound assessment and utilisation of clinical guidelines, conduct screening, and provide patient education that promotes self management, including early and appropriate referrals to specialist services. The most important ingredient in effective care management is the relationship that is fostered with the individual and family, according to Boyd (2004) who believes that the nurse becomes the client's interpreter thus understanding the vast complexities of chronic illness care through this relationship. Boyd went on to postulate that effective management of chronic illness needed to begin in primary care with practice nurses becoming key providers.

Living with a chronic condition may involve self-management, health education, and being involved with a range of health care providers. As this population is likely to be enrolled with a PHO and expected to access general practice services, it appeared to the researcher, essential to explore the practice nurses'

perceptions of the current contribution they make to the care of individuals with chronic conditions.

Conclusion

The practice nurse role in New Zealand in 2006 is within a changing environment, with an increased emphasis on the role of PHC. This emphasis on PHC is in keeping with the educational preparation of the nurse within a holistic focus. This research has been motivated by the desire to explore and understand the practice nurses' perceptions of their contribution to the care of individuals with chronic conditions. It is important to understand the current contribution of practice nurses to both fully appreciate this, and inform the new roles for practice nurses in the care of individuals with chronic conditions.

Layout of this thesis

This thesis is presented as follows: The methodology will be explained, and the literature review undertaken prior to the thesis will be laid out. The literature review supports the need for the research to be undertaken, due to the limited literature on the role of the practice nurse with individuals with chronic conditions within the New Zealand context. Following this the data chapters are presented as three themes to include preparation of the individual for an appointment at the general practice, with the GP or practice nurse, nursing care by the practice nurse at the general practice, and the giving of information. Subsequent to this, is a chapter on the dualities that exist for the practice nurse, placed within available literature. The discussion chapter provides a summary and conclusions, with recommendations for practice, and further research explored.

Chapter 2

Research design and method

Introduction

Qualitative research provides a way of looking at human experience, allowing the researcher a view of a problem or issue from an emic perspective, the perspective of the participant (Field & Morse, 1985). Qualitative methods are described as being appropriate when studying topics about which little or nothing is known, as they can assist in theory building which can then be tested. This approach is being used to obtain an 'insiders view', and researchers within such a qualitative paradigm believe that social reality exists as meaningful interaction between individuals (Llewellyn, Sullivan, & Minichiello, 1999; Marcus & Liehr, 1998). In this study an exploratory descriptive approach has been used to discover practice nurses' perceptions of their contribution to the care of individuals with chronic conditions. This chapter will discuss the theoretical perspective of exploratory descriptive research, and its application to this study.

Theoretical perspective

The theoretical framework used falls within the interpretive qualitative paradigm and an exploratory descriptive approach. In qualitative research the process is mainly inductive, where the researcher builds abstractions, concepts, hypotheses and theories from details (Cresswell, 1994). This approach embraces the wholeness of individuals, focussing on human experiences in naturalistic settings. The qualitative researcher believes that unique human beings attribute meaning to their experiences and these evolve within life's context, with human behaviour going beyond what can be objectively observed (Marcus & Liehr, 1998; Minichiello, Fulton, & Sullivan, 1999). In order to gain an understanding of the contribution of practice nurses to the care of individuals with chronic conditions, it is necessary to consider practice nurses' perceptions of their experience within their unique

practice settings. By asking practice nurses to describe both what they perceive they do and how they do it, the endeavour is to gain an insight into this area of interest.

From an interpretive view, to understand a particular social action, the inquirer must grasp the meanings that constitute action. As such the qualitative design is focussed on understanding social settings, not necessarily making predictions (Denzin & Lincoln, 2000). The social setting under enquiry is the practice context within which the practice nurse is employed within the New Zealand health care system. The social setting will be further informed by how the particular contribution of the practice nurse is determined, and the nurses' perceptions of knowledge level, ongoing education and professional development. This study endeavours to explore the social reality of the practice nurses' whilst focussing on their experiences, which constitute their actions, within their practice nurse role.

Methodology

According to Axford, Minichiello, Coulson and O'Brien (1999) descriptive research enables health care professionals to describe what exists in practice, to classify information for use in the health care disciplines, or to discover new information. Qualitative descriptive studies aim to provide a comprehensive summary of events in everyday terms. The description entails the presentation of the facts in everyday language, in contrast to other methods such as phenomenology, which represent events in other terms (Sandelowski, 2000).

Qualitative description is also depicted as especially amenable to obtaining straight and largely unadorned answers to questions of special relevance to practitioners and policy makers according to Sandelowski (2000). This further informed my choice of an exploratory descriptive approach, within the context of the increased emphasis placed upon the work, and potential role, of practice nurses within the evolving health environment.

Qualitative data are described by Miles and Huberman (1994) as being not so much about behaviour as about actions, which carry with them intentions and meanings, which lead to consequences. Those actions always occur in specific situations within a social and historical context, which influences how they are interpreted

by both insiders and the researcher as an outsider. A qualitative approach was used in order to bring together data within the specific context of the practice nurse in the general practice setting, and within the wider context of the current organisation of nursing services.

Method

Participant recruitment

Participants were purposefully recruited with the ultimate goal of purposive sampling being to obtain cases deemed information-rich for the purposes of the study (Sandelowski, 2000). The chosen population were practice nurses. Those nurses whose sole responsibility was the professional or educational development of practice nurses were excluded from the study population. The nurses were employed in practices recently included within PHOs in the research area and included solo, group and accident and medical (A & M) general practices. To be eligible to participate it was recommended that the participants be accessible for the proposed duration of the study, of twelve to eighteen months, until data collection was complete, in case of a need to return for clarification of data or further interviews. This was communicated to the prospective participants.

Ethical approval was gained for the study, from the Massey University Palmerston North campus Human Ethics Committee (Appendix 1). Initial contact was made with potential participants by a presentation at a local College Of Practice Nurses'(COPN) meeting, with a flyer (Appendix 2) being initially sent out to members prior to the meeting with the COPN monthly newsletter. This invited potential participants to contact the researcher. Upon contact, and following opportunity for further discussion, an information sheet (Appendix 3) was sent to the potential participant's nominated address. This outlined the purpose of the research and the contact information for the researcher, supervisor and ethics committee. Several participants expressed an interest from this forum and information sheets were sent to them. A follow up phone call initiated by the participants ascertained suitability and willingness to participate. This method of contact recruited five participants.

The next stage involved a further flyer accompanied by an introductory letter (Appendix 4) being sent to the practice manager of all general practices as identified from the local telephone directory. A follow-up phone call was made to the practice nurse(s) in the practice; those indicating interest were sent an information sheet. This yielded a further six participants. Participant recruitment continued until no new themes emerged from the data of the interviews. Eleven nurses participated in the research.

Table 1. Demographics of the practice nurse participants

Number	11
Sex	All female
Length of time since nursing registration	Range: 12-32 years, Average: 23 years
Length of time practice nursing	Range: 1-23 years, Average: 10 years
Number of GPs in practice Full time equivalents(FTEs)	Range:1-12, Average: 3.2 GPs
Number of Practice Nurses in practice FTEs	Range:1-10, Average: 2.8 PNs
Hours worked by participants per week	Range: 8-40, Average: 27 hours.

Informed and voluntary consent

Informed consent was obtained first orally, then in writing as per Appendix 5. Informed consent is an ethical requirement and research participants have the right to be informed about the nature and consequences of participation in research. To support the gaining of informed consent the information sheet outlined the purpose of the research, the recruitment process, the participant involvement, confidentiality and participant protection, researcher obligations, participant rights and the contact details of the researcher, supervisor and chairperson of the Massey University Human Ethics Committee. This clearly outlined the participants' prerogative to ask and have answered any questions they may have had, and to withdraw from the study up until completion of data collection. Through this process the participants had time to consider their involvement and contacts were primarily initiated by them.

The written informed consent will be securely stored at Massey University and will be held for a minimum of five years as recommended by the 2004 Massey University Health Ethics Committee Code of Ethical Conduct for Research, Teaching and Evaluations Involving Human Participants. This is also a requirement of the regional ethics committee.

Data collection

The participants were invited to take part in an interview at a time and venue suitable to the participant and the researcher. Data were collected by semi-structured interviews which were audio taped with participant permission, and transcribed verbatim. These interviews ranged in duration from forty-five to ninety minutes. The transcriber signed a confidentiality agreement (appendix 6). The audiotapes were each checked against the transcript for accuracy by the researcher.

Interviews are described as allowing for richer and more complex data to be collected, particularly when open-ended responses are sought (Grey, 1998) as in this study. A good interview encourages a reflective process where participants can explore their thoughts, feelings and experiences (Lupton, 1999). Attempts to establish rapport were made by acknowledgment of common language emphasising common rather than uncommon ground. Initial questions were accordingly associated with clinical experience (the participant's nursing history which was 'common ground') enhancing rapport according to Minichiello, Madison, Hays, Courtney and St John (1999).

A broad interview guide was utilised initially as summarised in Table 2. The interview guide is generally considered to be a list of questions, or a series of issues brought to the interview by the researcher. The sequencing and asking of the questions is highly flexible, and the guide helps the interviewer focus on the participant, and maintain consistency between interviews (Minichiello, Madison et al., 1999).

The following table outlines the initial questions used in the initial interviews.

Table 2. Questions in initial interviews

Can you tell me about your nursing history to date?
Can you tell me about your care of persons with chronic conditions?
Can you tell me what you do?
Can you tell me what others do?
Can you tell me about the individual's role? i.e. in gaining information
Can you tell me about any ongoing education you have recently attended?

Following analysis of the initial five interviews, the questions were further developed to address gaps in the data collected; these questions are summarised in Table three. A common feature of qualitative studies is that the initial research question is often revised during the research process, moving from a general to a focussed research area (Minichiello, Fulton & Sullivan, 1999). New participants were recruited until no new themes were evident from the concurrently occurring data analysis. A further six participants were recruited to bring to 11 in total.

Table 3. Questions in subsequent interviews

Can you describe the range of conditions individuals have, that you provide care for?
Can you describe your role in education with individuals with chronic conditions?
Can you describe the individual's role in education?
Can you describe how you respond to individuals that choose not to comply with the general practice 'rules' around follow up etc?
Can you describe your response when you cannot meet the individual's needs? i.e. knowledge outside your level of expertise?

During the interviews the use of field notes was employed whereby I jotted down "key phrases and memory triggers" (Russell, 1999, p. 441) which I returned to during the course of the interview to further explore the descriptions. Field notes are a descriptive account of what is observed and heard (Russell). These phrases were returned to immediately following the interview, and were expanded, to

summarise the main themes and discussion into interview summaries. The following table is an example of an interview summary.

Table 4. Interview summary

<p>Demographics: approx 6000 patients. 2.2 FTE practice nurses. 2 FTE GPs. History of obstetrics, private hospital, practice nursing for 5 years in same location.</p>
<p>Contribution to care: patients see GP first. Asked to educate. Care led by GP initially.</p> <p>Reviews clinical notes, asks about what GP has already covered before plans care. Offers case management to newly diagnosed individuals with same practice nurse. Accessible by telephone. Nurses do telephone triage, use guidelines. Likes to meet patient expectations. Feels could refer more if enabled to do so. Does free annual check (FAC) and other diabetes checks. Reviews progress from individuals' perspective. Initiates follow up care to suit individual, provides regular care initially following diagnosis. Likes cardiovascular disease (cvd) care area: lipids and risk assessment. Not a lot of ongoing cvd care, this being GP led. Uses guidelines, GPs don't always follow recommendations the practice nurses make. Provides acute assessment of chronic exacerbations, nurse always accessible to do this. Initiates emergency management and gains input from others if necessary. Feels cvd and respiratory care not structured enough, not standardised. Does follow up of abnormal blood tests, sent by GP after they have screened these. Thinks Care Plus will be useful and practice nurses will do most of the intended work. Variety of education recently, feels needs to be proactive to access.</p>

Data analysis

Qualitative data analysis is an interactive process. As an exploratory descriptive study, data were read over and over again, in search of deeper understandings (Polit, Beck & Hungler, 2001). Qualitative analysis seeks to address the questions of 'how things are said' and the underlying symbolic meaning of texts. This is done through examining the way language and visual imagery combine to create meaning (Lupton, 1999).

The exploratory descriptive approach was supported by the analysis and presentation of the data as a comprehensive summary of the events, with thematic content analysis employed, as this is suitable for research using semi-structured open-ended interviews where the interviews are recorded and fully transcribed (Burnard, 1996). With a focus on detail, qualitative analysis is usually applied to a far smaller sample of texts (Lupton, 1999). The aim of thematic content analysis is to produce a detailed and systematic recording of the themes and issues addressed in the interviews and to then link the themes and interviews together under a reasonably exhaustive category system (Burnard). This method of analysis enabled the systematic recording of the content of the participant interviews as themes and sub-themes.

According to Miles and Huberman (1994), data analysis consists of three concurrent flows of activity- data reduction, data display and conclusion drawing/verification. Data reduction consists of a process of selection, focussing, simplification, abstraction and transformation of the data of field notes and transcriptions, occurring continuously throughout the life of the research. Data display is where data are compressed, and displayed aiming at assembling this organised information into an immediately accessible compact form. This allows the analyst to see what is happening, and draw specific conclusions. Conclusion drawing and verification is the third stage of analysis, and from the start of data collection the qualitative researcher is beginning to decide what things mean, noting regularities and patterns, explanations and propositions. Conclusions are also verified as the analysis proceeds (Miles & Huberman).

An editing style of analysis was utilised, whereby as the researcher I acted as an interpreter, reading through the data in search of meaningful segments. Once the segments were identified and reviewed, a categorisation scheme and corresponding codes were developed that could be used to sort and organise the data. Following this, a search for patterns and structures that connected the thematic categories occurred, in accordance with an editing style as described by Polit et al. (2001). This necessitated the reading and rereading of transcripts and the coded categories of data. As the aim of the research was primarily descriptive, the categories used were quite concrete.

Codes were used to name categories in the initial data analysis. Codes are labels for assigning units of meaning to the descriptive information, attached to chunks

of text. Codes are then used to retrieve and organise this information (Miles & Huberman, 1994). The following table details the initial data analysis categories.

Table 5. Initial data categories

Experience	Demographics
Confidence	Work schedule
Telephone contact	Face to face contact
Recall	Screening
Referral	Relationships
Education and professional development	

There were varying amounts of data in each category within each interview. Data were recorded under categories with line references to enable easy return to the transcript when required. The identified categories were viewed as distinct sets of data, written in an easily accessible compressed form. The following table is an example of data under a category from one interview.

Table 6. Data category example

<p><u>No. 3. Work schedule</u></p> <ul style="list-style-type: none"> • Current external clinic that practice nurses attend 3 hrs per day (45). • Going to external clinic interrupts the day (52). • Practice increasingly busy (57) • Nurses divide time between roles, alternate between clinics and phone (58-61) • 'Phone' nurse gets interrupted to deal with emergencies (64) • Recent change from 'drop in' to appointment book for nurses (70). • 15 min appointment time, same as GPs (92). • May double book appointments (93). • Receptionists determine time allowances (92). • Views 15 mins as opportunity to spend time with pts (101). • 30 mins for newly diagnosed diabetes (108). • Nurse can determine time allocation (109). • 'Survival mode' past year. Menz B campaign. No extra staff employed. Coped with increased workload (180). • Will have increased time available for dedicated recall time (360) • Time constraints (42). • Reactive nature of general practice work (420).

Identifiable patterns or themes became apparent across the interview data. Further analysis occurred by the process of mind mapping of the themes and how

these were linked (Appendix 7). The themes that emerged as discussed within the findings chapters of this thesis are summarised in the following table. The themes and sub-themes are inextricably interlinked, with aspects being replicated across each.

Table 7. Final themes and sub themes

<i>Themes</i>	<i>Sub themes</i>
Preparation of the individual for an appointment	Recall, monitoring, telephone contact, regular medication facilitation.
Care provided by the practice nurse at the general practice	Planned visits, unplanned visits, delegated care, rules around follow up
The giving of information	At initial diagnosis, acute context, ongoing context, knowledge base, role of individual, referral

Reporting of findings

The findings have been presented in a detailed discussion of the identified themes and sub-themes. The findings are also interpreted to describe the meaning of the data, and placed within the available literature, a process which may pose further questions (Creswell, 2003). The expected outcome of qualitative descriptive studies is a straight descriptive summary of the informational contents of the data, organised in a way that best fits the data (Sandelowski, 2000). This summary serves to identify themes and construct a description of the phenomena (Creswell).

Data storage

The data will be kept for a minimum of five years and will then be destroyed. At the completion of the research the audio tapes will be kept for a minimum period of five years in case of an audit of the research, as agreed by the participants. No participants requested their tapes to be returned to them.

Quality of the research

A major feature of well collected qualitative data according to Miles and Huberman (1994) is that it focuses on ordinary events in natural settings, giving the researcher a strong feel for what real life is. Confidence in the research is

reinforced by data collection occurring in close proximity to a specific situation, the emphasis being on a specific case, embedded within its context, where influences of the local understanding are not stripped away. Within this research the data were collected by interviews, exploring the participants' individual contributions within the context of their specific general practice setting.

A further feature of qualitative data is "their richness and holism with strong potential for revealing complexity", (Miles & Huberman, 1994, p. 10). Such data are described as providing thick descriptions that are vivid, and nested in the real context. The data collected in this study provided rich and varied descriptions of the complex contexts of the practice nurse participants.

Validity of qualitative research refers to the internal logic of the research and how well the findings are interpreted and contradictions or similarities are accounted for (Lupton, 1999; Minichiello et al., 1999). Validity was maintained within this research through a variety of methods. I endeavoured to be consistent with the aim of the research and use of interview questions. Through the exploratory descriptive approach, a consistent approach to the description and interpretation of the data was maintained through the role of the supervisor in the research reviewing each transcript and the interpretations of these. Claims to validity may be strengthened by involving others in the interpretation of the data and comparing notes, discussing in detail the possible reasons for differing interpretations. Comparison may also be made with other research in the area (Lupton). In addition to this, I returned to a selection of participants and discussed with them the summary of my findings under the three themes and sub-themes. I asked the participants to give me feedback on my interpretation of the description. The participants validated my interpretation of the findings.

There were identified limitations to using this method of research, in that the findings cannot be generalised due to the individual and varied nature of the participant's practice context, and the purposeful recruitment (LoBiondo-Wood & Haber, 1998).

Ethical issues

The role of the researcher

The role of the researcher in qualitative inquiry is described as a research instrument, and the researcher should have the ability to observe behaviour and sound skills in interviewing (Patton, 2002). During the conduct of the research it was vital, that as the researcher I established rapport with the participants to enable my role as both observer and interviewer. This meant that I was required to see the situation from the participant's viewpoint, rather than superimposing my own world and my preconceptions upon them (Fontana & Frey, 2000). The rapport was enhanced as previously described under data collection.

Because of my own personal experiences as a practice nurse, I was required to take care to refrain from making assumptions and asking questions around my own understanding of the practice nurse role, to allow the participants to guide the interview conversation. The system of recording field notes (such as of participant descriptions) was employed, to enable me to return to these at an appropriate point in the interview, thereby avoiding interrupting the participant.

Additionally, accountability to the participants, and the relationship between the researcher and the participant is key (Grbich, 1999). A potential problematic issue that needed to be addressed stemmed from the researcher's degree of involvement with the group under study, as interviewers are increasingly being seen as active participants in the interactions with respondents. Interviews are seen as negotiated accomplishments of both the interviewers and respondents that are shaped by the contexts and situations in which they take place (Fontana & Frey, 2000). During the course of the interviews this was reinforced by restating the purpose of the research and the research question to the participants. As a nurse I had an interest in the outcome of the research but it remained essential that I maintained the role of researcher. This was enabled by direction of my supervisor for the research, as I undertook the research as a student.

Management of privacy, confidentiality and risk

Under the ethical principle of beneficence, researchers are required to protect the well being of subjects. This includes avoiding or minimising harm, as much as is possible. Confidentiality also needs to be a primary safeguard (Christians, 2000).

Protecting participants' confidentiality and privacy was managed in a variety of ways. The information sheets and transcripts were posted to the participant's nominated address, whether this was home or work in order to safeguard privacy. Interviews were conducted at the participant's venue of choice, mostly outside of their usual workplace. Through these measures the practice nurse could choose whether she shared her participation in the research with anybody from her workplace, (including her employer). Some interviews, however, were conducted at workplaces, at the request of the participants, with the consent of the employers.

There was also the need to negotiate the scope of the research as the project unfolded to ensure that informed consent was maintained. As outlined in the information sheet, the participant had the right to withdraw their contribution to the research at any time up until the end of data collection. Participants were notified when data collection was complete in June 2006.

As outlined in the information sheet, to further manage confidentiality related to the data collected, access to the audio taped recordings was restricted to the researcher and transcriber. Access to the raw data was limited to the researcher. Access to the written recordings was limited to the researcher, supervisor, and transcriber (during typing of the transcripts only). The transcriber signed an agreement of confidentiality before commencing transcription of the interviews (Appendix 6). The data collected during the study were kept in a locked cabinet and on a password protected computer. Once data were transcribed and coded, every care was taken to ensure there were no identifiable features. Any written reports of the data were name coded so no person could be potentially identifiable and pseudonyms were used for the participants.

To minimise the risk to the employment situation of the practice nurses, every care was taken in the writing of the research to avoid any participant being personally identifiable, the afore mentioned participant nomination of address for

information to be mailed to, and by not discussing the identity of any participants of the research with anybody.

There were no immediate identified benefits to the participants, but long term benefits for nursing in general may include the ability to locate and describe practice nurses' perceptions of their contribution to the care of individuals with chronic conditions, in the general practice context.

Conclusion

The research undertaken is qualitative in nature, through an exploratory descriptive approach. This approach was chosen as it appeared appropriate to the chosen area of study, providing a view which focuses on the participants' experiences. As such the research provides a compelling account of the participants' perceptions, presented within the varied contexts within which the participants work. There has been no attempt to make predictions, with a primary aim to describe what occurs in practice. The three themes to come forward from the data will be discussed in the subsequent chapters. The following chapter will present the literature review undertaken prior to commencement of the research.

Chapter 3

Literature review

Introduction

The objectives of a literature review include determining what is known and not known about a subject, determining gaps, consistencies and inconsistencies in the literature, discovering unanswered questions, and the generation of useful research questions (Krainovich-Miller, 1998). The literature review was purposefully aimed at providing a context to begin the study with, and was kept broad to provide a level of control around preconceived ideas regarding the role of the practice nurse with individuals with chronic conditions.

A search was conducted via the Massey University Library website. Databases accessed were: Medline, CINAHL (Cumulative Index to Nursing and Allied Health Literature), Web of Science, and Ebsco host. Search words utilised included practice nurse(s/ing), chronic illness/disease/condition, general practice, nursing roles, primary care, primary health care, advanced nursing practice, and teamwork. The publication dates were limited to 1990-2004, to draw upon more recent literature, and international literature was reviewed. In addition, references and cited authors were accessed from research articles. This chapter will present the findings of the literature review.

The international perspective of nursing and role development

When considering the context of practice nurses in New Zealand in the developing primary health care environment, it is essential to consider the influences that are informing the development of the New Zealand health sector. With the implementation of the PHC strategy (King, 2001) there is an unprecedented emphasis on the integral role of the PHC sector and PHC nursing. It is therefore important to consider international literature to examine both the history of

development of these PHC sectors, and the effect on, and role of, practice nurses within these.

It is also important to differentiate between primary health care and primary care. Primary health care is “essential health care made accessible at a cost a country and community can afford, with methods that are practical, scientifically sound and socially acceptable” Alma Ata declaration as cited in World Health Organisation (1998). Whereas primary care is “the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Donaldson et al. as cited in Starfield, Shi and Macinko, 2005). As such primary care can be described as an aspect of primary health care, with primary health care described as both a “level of delivery and as an approach to health care” (Alma Ata as cited in Baum, 2002, pp.532).

The role development of practice nurses in the United Kingdom (UK) setting with the evolution of Primary Care Groups (PCGs), is comparable to the New Zealand attempt to improve the health status of its citizens and to ensure health professionals are part of PHC teams. A component of the UK’s strategy for modernising the National Health Service was the development of these PCGs, which began in 1999. These were aimed at improving the health of their communities and maximising effective use of resources by collaborating with other groups and sharing expertise. Promoting access to health care was an important feature, particularly for people who have been poorly served traditionally. The PCGs were charged with developing primary and community health services, commissioning hospital services and improving the health of their communities. The aim was that by 2004 all of these groups would be part of Primary Care Trusts (PCTs) controlling the budget for providing most of the healthcare for the populations they serve (Wilkin, Dowsell, & Leese, 2001).

Included in the UK NHS modernisation agenda is the aim to address the growing number of individuals living with chronic or ‘lifelong’ conditions. Integrated nursing teams (INTs) were introduced by the NHS as a component of the development of PCGs and PCTs. These INTs were evaluated by Gerrish (1999) in a qualitative study, with criteria identified as key to success to include team working, effective communication, orientation to general practice, changes in

working practice and responsiveness to change. The empowerment of nurses through INTs was shown to provide nursing with a greater opportunity to realise their potential contribution to care. Progress was achieved by INTs through the development of flexible working practices across boundaries, providing an important foundation for the partnership and collaboration advocated in new primary care policy and practice (Gerrish).

In reviewing the views of the various stakeholders on the impact of PCGs and PCTs in the UK and nursing role development, contrasting views emerged around both nursing roles and nursing governance. Forty nine GPs in a small longitudinal study (Dowsell, Harrison & Wright, 2002) described PCGs having little impact on their practice, with minimal knowledge around PCG activity and priorities. PCGs were seen as an erosion of GPs' autonomy, a feature that historically GPs perceive as central to their own role. However, they did perceive enhanced nursing services as an option to reduce their own workloads. This study raises questions around the education and preparation of all team members regarding changing roles, as it appears essential that all team members have an understanding of role changes within the team they work.

There is evidence in the literature of mechanisms to encourage and support nursing participation in health care system developments. An attempt to promote nursing participation in PCGs is described by Goodman, Wall and Reavey (2002). This small qualitative case study reviews a 'link nurse' role developed to function as a conduit between the NHS and the emerging PCGs, as an agent developing a collective community nursing voice to inform and respond to the PCG. While the link nurse was recognised as a vital connection and valuable conduit between the PCG and practitioners, no mechanisms existed to ensure that all PHC nurses had access to the nurse.

In support of findings of the study by Goodman et al. (2003), a large mixed method investigation of 72 PCGs reported that most PCGs consulted nurses over key policy areas, and perceived nurses as being supportive of nursing service changes such as integrated nursing teams. PCGs were seen to offer nurses a broad range of opportunities to develop new skills and roles, with an increase in development of specialised nursing roles (Dowsell, Wilkin, Kirk, & Banks-Smith, 2002). This study's findings are limited by the participant selection of PCG/PCT chairs and chief officers, which were predominantly GPs. This selection was based

on the premise that these were the most influential board members in terms of policy development including that which impacted upon nursing. As such it appears inappropriate for these participants to comment on nurses' perceptions of PCG development. Nursing representation on PCG boards was described as an opportunity to participate, but it is apparent that medical dominance is a recurrent theme. Further questions arise from this particular study, in terms of what the nursing members' views in the PCGs were (Dowsell et al.).

Perhaps in acknowledgment of this limitation, a further study by Dowsell, Wilkin and Banks-Smith in 2002, investigated the experience, and perceived influence of nurses serving on PCG boards. As part of a longitudinal study a 15% random sample of nurses was surveyed with a 73% response rate. The participants highlighted difficulties in fulfilling dual roles with only a small percentage feeling they were well prepared for the governance role. Nurses perceived their influence as limited compared with GPs, but a positive finding was that over 52% were communicating information to other primary care and community nurses, rating communication with these groups as good or better. This study described nursings' ability to have input as likely to increase influence, confidence, and opportunities to contribute to local health policy. This includes the potential to result in more coordinated community and primary care services, with inherent consideration of the implications for nursing staff (Dowsell, Wilkin & Banks-Smith).

In a participatory action research study community nurses' views on the impact of PCGs, also revealed varying levels of knowledge around changes amongst all nurses. Practice nurses had the greatest knowledge level (While & Dyson, 2002). It was considered that this varying knowledge was due to a lack of communication and inadequate information about the changes. Increasing workloads without adequate assessment of increasing roles was repeatedly identified by these nurses, and nursing engagement in governance roles was described as limited. This supports the recommendation for further research around the existence of national strategic planning to facilitate and support evolving nursing roles.

In reviewing how change in nursing roles is determined, and implementation managed, various themes support previous literature reviewed. A UK study investigating and implementing change within the nursing team, sought to gain user views, alongside team member views of services provided, roles and clarification of specialist roles required to meet patient needs, and analysis of

current team practice (Galvin et al., 1999). An action research methodology was used with the specific objectives of changing practice, and development and refinement of existing theory to underpin community nursing roles. Overall high levels of satisfaction were expressed by patients, with themes emerging from data informing the development of new roles and responsibilities. These included the importance of avoiding duplication of tasks, the need for a coordinated team approach, and locating leadership within the nursing team.

In further consideration of preparation and ongoing support of the nursing workforce for role development, difficulties are identified in a study by Adams, Lugsden, Chase, Arber and Bond (2000). In this study of NHS PCTs, managers describe varying degrees of strategic planning around skill mix changes, and nurse's report experiencing multiple negative outcomes, associated with skill mix changes, primarily related to having to undertake extended roles without adequate training nor assessment of workloads. Identified here is a lack of an explicit professionalisation strategy within nursing, resulting in the negative impact of extended role development (Adams et al.).

This is further supported by a UK study of the clinical role development of practice nurses (Walsh, Roe & Huntingdon 2003). This qualitative multiple case study describes nurses working in Personal Medical Service (PMS) pilots, adopting new roles and responsibilities. While it concludes that nurses are indeed working to maximise their contribution to primary care, it supports previous study findings in the varying degrees of role extension, many with no formal procedures. Securing of greater autonomy by nurses is described as the most significant motivator for nurses, to enable them to develop and enhance their practice, but this research does allude to the need for consistency around role development (Walsh et al.).

In the United States of America Primary Care Teams were developed in the Georgia region of Kaiser Permanente in 1997. These were developed with goals to increase patient satisfaction, improve health employer data and information set scores, and lower cost (Grumbach & Bodenheimer, 2004). Prior to the implementation of these teams, staff were trained in team orientated care. Each team received a budget based on the number of patients the team had, with risk adjustment according to age and disease severity. The authors of this article focused on how team members work together, seeking to understand how health

care teams can improve primary care practice. They deduced that cohesive health care teams possessed five key characteristics including: clear goals with measurable outcomes, clinical and administrative systems, division of labour, training of all team members, and effective communication (Grumbach & Bodenheimer). These characteristics are common themes emerging from the literature around the provision of care from the general practice setting. A limitation of reviewing the American concept is the orientation to primary care and general practice as opposed to primary health care and the wider primary health care environment. Similarities however can be drawn between the aims of the Kaiser Permanente Primary Care Teams and the intentions of the NZ Primary Health Care Strategy and the development of PHOs. Both incorporate the intention to control costs of health care and increase patient satisfaction, although the purpose of the PHC strategy is wider, as is the scope of the NHS health reforms in the UK.

The role of the Practice Nurse with individuals with chronic conditions

There is varying literature regarding the role of nurses working in general practice settings, with individuals with chronic conditions. In the UK the equivalent of the practice nurse is commonly referred to in the literature as the primary care nurse. Debbie Singh (2005a), in a rapid review of the literature on the work force implications of the UK long term conditions policy, provided a review of 172 studies. She concludes that regarding the role of nursing, many initiatives exist to improve the care of individuals with chronic or 'long term' conditions. Specifically regarding primary care nurses, there was evidence that nurses working in general practice were well regarded by people with chronic conditions. It was suggested that nurses can provide equivalent care to people with long term conditions to that provided by general practitioners. There were two types of nurses identified in the review, to include 'specialist nurses' referring to those focussing on people with one disease type, and generalist nurses, trained to provide care to people with a variety of health conditions (Singh).

The role of the primary care nurse in routine follow up of people with long term conditions was described as key, with evidence that this routine follow up by primary care nurses may improve quality of care and clinical outcomes for people

with long term conditions, especially diabetes. Further described was evidence that advanced primary nurses trained to provide care to people with one or more long term conditions can make a valuable contribution to disease management programmes (Singh, 2005a).

The New Zealand context and the role of the Practice Nurse

The impetus of the NZ PHC strategy (King, 2001) can be likened to the UK developments which began in 1999, a key difference being the exclusion thus far of any move to include fund holding for secondary care services within the PHO environment. There is a growing body of literature detailing the role of the nurse as a team member in the general practice setting, with international literature as summarised, signalling role development and expansion of roles for nurses in general practice as key components of PHC system redesign.

In considering aligning PHC nursing practice with community need, as is being attempted in New Zealand with the development of PHOs and health care services delivered to enrolled populations, literature points to the benefits of PHC focussed delivery of health care to those with chronic conditions. Atun (2004), in a synthesis report on the advantages and disadvantages of structuring a health care system to be more focussed on primary care reviewed published studies from 1980 to 2003. This review concludes that there are advantages of health care systems that rely more on PHC than specialist care. The general evidence confirmed improved population health outcomes and equity, more appropriate utilisation of services, and increased consumer satisfaction.

It was essential to examine the role of the practice nurse and team functioning in view of the employment relationship in the New Zealand context with practice nurses as employees of a private business. Freeman, Miller and Ross (2000), in a qualitative grounded theory study, explored issues around professional interaction which inhibited or supported teamwork, and concluded that medicine tended to hold a 'directive' philosophy, based upon hierarchy, with one person taking the lead by virtue of status and power, directing the actions of others, i.e. GPs directed nurses, therefore limiting the ability to communicate. Nursing, in contrast, is described as holding an 'integrative' philosophy with a commitment to collaborative care and team playing, assigning value to each professional's contributions. Meanings ascribed to teamwork therefore shape how people

communicate, and determine the level of role understanding deemed important (Freeman et al.).

This is further supported by Crampton, Davis and Lay-Yee (2005) in an article describing the development of primary care teams in New Zealand. Within the developing PHC environment, these authors refer to practice nurses as “hostage to the fortunes of their GP employers” (p. 236), with the employment model limiting their involvement in decision and policy making, career development, and expansion of their role.

In consideration of the respective functions and roles of the members of the general practice team, effective General Practice Teams need to demonstrate partnerships, and collaboration is described as the essence of the partnership expected in PHC (MacIntosh & McCormack, 2001). Inherent in the notion of collaboration is the idea of active participation and it is based on the assumption that it enhances the capacity of people and organisations to achieve health status goals, and the power to combine the perspectives, resources and skills of a group of people, described as synergistic (MacIntosh & McCormack).

Lasker, Weiss and Miller (2001) hypothesise that collaboration is the key mechanism through which partnerships gain an advantage over single agents in addressing health system issues. In this study the authors describe partnership synergy as a practical framework for strengthening the collaborative advantage and it is described as being applicable to all forms of collaboration. This is manifested in the thinking and actions that result from collaboration and the relationship of partnerships to the broader community. In application to the New Zealand context, the concept of synergy is attractive in considering the objectives of the PHC strategy (King, 2001), the partnership philosophy inherent in the concept of PHOs, and the role of the general practice team within which nurses are an integral component.

As an integral aspect of collaboration, many avenues of communication are necessary. The practice nurse within the general practice team has the daily need to communicate with a variety of individuals inclusive of clients/family/whanau, practice members and wider health and social service team members. The need for effective communication in the provision of healthcare is supported by a

number of research studies (Dowsell, Wilkin et al., 2002; Galvin et al., 1999; Goodman et al., 2002; Long, 1996; Mackereth, 1995; Scholes & Vaughan, 2002; Williams & Laungani, 1999).

In further consideration of collaboration and teamwork among the general practice team members, there is varying research regarding team member perspectives. In a qualitative action research study by Long (1996), an exploration of member's perceptions of teamwork in two PHC teams in general practice was undertaken. This revealed differing participant views of teamwork, and clear examples of teamwork in practice. Lack of communication was signalled as causing conflict, and interpersonal differences needed to be discussed to enable a clear understanding of group processes and team function. Natural leadership was assumed by the senior partner in the practice, and GPs assumed they were the natural leaders. This hierarchy in leadership was seen to exert influence on opportunities for professional development. This finding is supported by the findings of the New Zealand study by Crampton et al. (2005), describing the limiting effect of the employment model on the practice nurses' ability to influence decision making, career development and role expansion.

There is limited New Zealand literature regarding the role of the practice nurse in the care of individuals with chronic conditions. Prior to commencing this research, the single identified New Zealand study, a cross-sectional survey of 149 practice nurses, revealed practice nurses to have a low postgraduate qualification enrolment with a significant proportion having not undertaken any professional development, alongside varied skill level and utilisation of nursing skills (Lightfoot et al., 1999). These findings are comparable to an Australian based study and an earlier study in the UK prior to the development of PCGs and PCTs, which describe practice nurses as being restricted to assistive task orientated roles largely determined by their medical employers, with limitations due to professional development constraints (Mackereth, 1995; Patterson, Del Mar & Najman, 1999). Two further small Australian studies (Blue & Fitzgerald, 2002; Willis, Condon & Litt, 2000) concurred with these findings, revealing significant status and power differences between GPs and nurses, and funding structures maintaining a supervisory relationship of doctor over nurse. These studies sought to investigate not only the relationship between GPs and practice nurses, but also barriers to effective team relations.

Furthermore, in a theoretical article to develop a client focussed approach to advanced practice nurse management specifically in chronic illness, Cumbie, Conley and Burman (2004) summarised that to be effective, chronic care needs to be flexible, collaborative and individualised. This article included two New Zealand studies and reported patients seeing multiple health care professionals, receiving conflicting information and feeling frustrated and confused. The identified need for collaborative care supports the literature reviewed.

Conclusion

The literature review undertaken prior to this study highlights a range of challenges inherent in redesigning health systems. The New Zealand literature was restricted, revealing nurses to have limited post graduate educational qualification, were undertaking restricted roles, and working within employment models that limited their ability to influence opportunities for professional development, and decision making.

These findings are comparable to the international literature viewed regarding developing nursing roles, and variation in nurses' ability to influence decision making regarding extended nursing roles. The findings of the review conducted by Singh (2005b) provide a broad context to begin to investigate the scope of the role of practice nurses in the care of individuals with chronic conditions. Key ideas to emerge from this review include those related to membership of a team such as the general practice team. These incorporated concepts of hierarchical relationships between GPs as employers and practice nurses as employees, the importance of effective communication and collaboration, and the value of adequate preparation and support for nurses undertaking new and extended roles.

This study was undertaken purposefully prior to the General Practice implementation in the study area, of the Ministry of Health "Care Plus" system of care, to be provided to persons with two or more chronic conditions identified as needing increased clinical input. While the limited New Zealand literature confines the ability to compare the findings of this research, this and the international literature provide the scope to begin to understand the current role of the contribution of practice nurses to the care of individuals with chronic conditions. Further consideration of the literature will be within the chapter on

dualities of practice nursing and the discussion chapter. The next chapter presents the findings of this research.

Chapter 4

Preparation of the individual for an appointment at the General Practice

Introduction

Preparation of the individual for an appointment at the general practice was a core theme of this study. Practice nurse participants all described an array of responsibilities in the preparation of the individual for an appointment at the general practice regarding their chronic condition(s), either with the practice nurse or the GP. Contributing to this preparation were systems of following up or 'recall' of the individual, telephone encounters both individual and practice nurse initiated, and communication with the individual and the wider health care team, primarily the GP. This preparation served to provide a level of care both before visits, and as an ongoing function between visits, as described in the next chapter. This preparation role also served as an adjunct to the GP role, by both prompting the GP such as of care due, and in translating after the individual had seen the GP, as a check on the individual's understanding.

A wide range of chronic conditions for which individuals sought care were described by the practice nurses, primarily including the more prevalent conditions referred to in the background chapter of diabetes, cardiovascular diseases and respiratory diseases. Less commonly described were chronic conditions such as pain, mental illness, multiple sclerosis, arthritis, palliative care, grief, and renal disease. It was difficult at times to separate the practice nurse role generally within their everyday practice, from the role identified specifically regarding chronic conditions. No participants provided descriptions of care for individuals with more than one chronic condition, with the nurse's focus remaining on separate diagnosed chronic conditions.

Practice nurse participants described two contexts within which they interacted with the individual with a chronic condition, to include planned (from the

individuals perspective) and unplanned (as unexpected by the practice nurse) situations, inclusive of both telephone contacts, and face to face visits. This chapter will outline the role of the practice nurse prior to and between an individual's visit(s) to the general practice.

Telephone contacts

Patient initiated

All participants described being available to the general practice patients during office hours via the telephone. Participants recalled numerous telephone contacts regarding acute situations within the context of a diagnosed chronic condition. The practice nurse response to the telephone call was frequently described as the assessment of the individual's need for an appointment.

The phones operate from 8.30 to 5.30. The ideal is, somebody will be able to answer them straight away and that's a really important thing for the person at the other end. It might be something simple they want to know, like "my asthma inhaler won't work and I'm due to have my puff" and they want to know now what to do with it, how they can get it replaced or whatever they want to do. I guess it's trouble shooting really. They'll also ring up if they've perhaps had a bad night, and you can assess over the phone whether they need to come in straight away, again asthma. (Brenda, line 445)

A lot of people will actually ring and say "Do I need to come and see the Doctor about my results?" and if the results are such I'll say "yes, I think you should". (Angela, line 421)

Emergency telephone triage and the initiation of the appropriate transport for the individual to health care services was also described, supported in some practices through the use of telephone guidelines by the nurse.

When people present acutely, they either ring and ask what's going on and are told to come down now or call an ambulance, or they present at reception with chest pain. The other thing I didn't mention is that we now have telephone guidelines so when people ring up with certain signs and symptoms, you can flick to that page and it will give you advice on what to ask and say. You will tailor that to the individual but it gives you cues about what to do. It's not to say that someone who's not a nurse should do that, because there's not enough information there, but it's giving you back stop information if you like. (Elaine, line 445)

Telephone contact was not only with the individual diagnosed with a chronic condition, but also with family/whanau and caregivers. Practice nurses also described being responsive to increased family concern, thus increasing the practice nurse level of concern regarding the individual.

All the signals they or their family are sending me, sometimes families' attitudes can tell you a lot too (whether they are just fed up or genuinely concerned) when you've got a spouse who's really worried, that's more of a concern because you know that's not normal. (Helen, line 481)

Helen described numerous phone calls regarding individuals with mental illness and intellectual disabilities. These involved spending a lot of time listening and talking those people through situations.

They have all sorts of problems, from being off with medications to being distressed, violent. Some of them are living now in those managed houses and we get lots of phone calls from them... One in particular that springs to mind is a schizophrenic, and she does hear voices, so we know when she's having a bad time because there are lots of phone calls, as in several a day sometimes. It's really just talking her through, persuading her that the voices actually are the voices and she does understand, she knows they are talking to her but has difficulty sometimes differentiating between reality and the voices. Sometimes we encourage her to come in, sometimes it's just a medication tweak, or getting her out of her home. (Helen, line 74)

The nurse may then encourage the individual to attend the general practice for a medical review or for social reasons. This practice nurse clearly saw the general practice as a place to address social needs such as isolation.

With the less commonly described chronic conditions, telephone interaction appeared to be less structured and more informal. Helen described spending time listening.

Listening is big one. One lady we have had little contact with [regarding multiple sclerosis]. She is a very private person and I think she and her husband are working through it together. She doesn't seem to need to contact us and that's good. Another who lives in the country, we do a lot of phone calls with her when she does come in we do a lot of talking. She is overdue for a smear test at the moment and doesn't see the point in having one so I'm working through that. She thinks she has enough to think about at the moment. (Helen, line 335)

Helen went on to describe this as involving 'not a lot of doing', and 'not active nursing care', with more of a general support role.

There's not a lot of "doing" with those people [with multiple sclerosis] because there is nothing to do really. It's not an active "lets change the dressing" type of thing, it's often just support they need. (Helen, line 355)

Helen went on to describe her perception of her contribution to their care.

I guess our only input then would be in a general way. We often only hear from them when they're in a bad patch. In remission we might get phone calls about pain relief. (Helen, line 365)

Another area described by several of the practice nurses was telephone interaction regarding palliative care needs. Several of the practice nurses described being part of a 'palliative care partnership', which is an initiative whereby funding assistance is provided via the general practice to the individual with palliative care needs, to support access to the general practice team. Helen described this role to include an assessment of symptoms, determination of the necessity for an appointment, and provision of a 'listening ear'.

A lot of talking, often symptom management. If they are undergoing active treatment we don't get those phone calls because they're in the system. The chemo/radio [therapy] reactions they've got a system for around the clock dealing with those. It's generally in between episodes of treatment where they might be down or getting other symptoms or different pain that will often generate a medical appointment, if something else is happening. (Helen, line 497)

In contrast Greta and Fiona both described a coordination role within this palliative care scheme, providing a description of complex telephone assessment by the practice nurse, and communication and collaboration with other health care team members to meet the needs of the individual at the time.

I'm the co-ordinator for palliative care partnership for our practice so I have the information and am often explaining the funding towards the end stage... This keeps the continuity going so when they get to the terminal phase you have that rapport there, emphasising the fact that no question is stupid, you can ring anytime and we will find an answer for you. Letting them know that their concerns are priority number 1. The Palliative Team are available any time. I can assess the situation and if I don't think it's a GP thing I can ring the Community Palliative Care Nurse and ask her opinion. I had a patient in a rest home who had a chest infection from his flu vaccine and was deteriorating rapidly. He was on a Picc [peripherally inserted central catheter] and fluids so I rang her and she informed me that he was deteriorating so fast that they were in the process of setting up a family meeting re Peg [percutaneous endoscopic gastrostomy] feeding etc. So it was good timing, she could bring it all up and then visit him that afternoon and let me know if there were any problems. (Greta, line 706)

With palliative care we tend to have runs on patients that are in that situation and families. It might be often liaising with hospice co-ordinators, talking with the spouses or family, sometimes in the practice, or over the phone, listening to the patient. (Fiona, line 397).

For some chronic conditions nurses described less contact with individuals, as care was centred on the pharmaceutical management conducted by the GP. For example regarding arthritis, interaction with the practice nurse was more likely to be telephone oriented.

Arthritis, home help and organising for their needs. Often they need pain killers. Just advocating for them, figuring out what else might help like exercise, pool therapy etc. (Fiona, line 401)

More likely to be a query made over the phone, because generally if it's to do with medication it will need the doctor's medical input. (Fiona, line 414)

Regarding this telephone contact, practice nurses viewed themselves as being accessible to the individual, and in particular, more accessible than specialist services that the individual may currently be accessing as well. Helen described this in the context of an individual with chronic pain.

One in particular, he had been discharged and pain management was a biggie for him, he was in and out of clinics but we're the easy one to phone because we're going to answer the phone. They've had a sequence of fob offs when they've tried to get back to the clinic, from what I hear from the patients. When they've had their clinic appointment it's been good but that's it until 3 months or when ever, they cannot get access back to that contact. (Helen, line 374)

When providing telephone assessment for those individuals whom it was considered unnecessary to attend the general practice immediately, practice nurses described giving advice and reassurance, with instructions to the individual regarding the need to phone the nurse back if the situation did not resolve. As an example, Helen describes the advice given to an individual diagnosed with diabetes, who has raised blood glucose levels.

And sometimes too if they've been unwell and their sugars have been up. They quite like to be reassured that, "you've had a chest infection, you've been on antibiotics, if your sugars are still up next week give me a ring". (Helen, line 567)

Participants described occasions where the individual was offered a choice of which practice nurse they wished to speak to when telephoning. This was primarily within practice settings where the practice nurse took a lead role in the coordination of the individual client's care. One participant described this as enhancing the relationship between the individual and the practice nurse, increasing the practice nurse's understanding of the individual's situation that contributed to the care of the individual but perhaps wasn't always documented.

I do explain that although we document all our notes, that when we see people quite frequently we form relationships and we start getting a lot of information and feeling that can't be documented so it's easier to pick up and leave off if you have the same nurse. But it's not the be all and end all if it doesn't work that way. We all work set days and that may

influence which nurse they have and I explain that there's not a problem with them ringing up and asking for a specific nurse. (Elaine, line 149)

This contribution of continuity of nurse, to the forming of relationships was further described by Greta.

Most people will speak to any nurse, but if you have had 2 -3 communications in succession with them, they will ask for you first. And as with everything, different personalities get on with different people. (Greta, line 765)

In contrast, one practice nurse described rules within her setting which limited the time the practice nurse could spend on the telephone with an individual. This was in response to an increased number of telephone conversations regarding follow up, and in this situation the practice nurse was required to offer the individual an appointment to see the GP.

A lot of the phone work (and it's encouraged not to spend too much time on the phone) is repeat prescriptions, acute things - patients wanting advice, trying to get in to see the doctor. (Claire, line 690)

Documentation of the telephone encounter was described by many.

We do a lot of phone contacts and it might not be the same nurse every time but all things should be documented into their notes. (Claire, line 688)

Write in the notes, why they called, what advice given, appointment made, review to call them back etc. (Fiona, line 293)

In general terms practice nurses spoke around the telephone contact as a role of interpretation of information and answering questions.

They ring in if their blood sugars are a bit haywire and they need some emergency advice, if they've gone hypo/hyper [glycaemic]. That can often be over the telephone, those ones, so you would instigate your assessment and get them in if needed. (Dianne, line 77)

The assessment and triage during these telephone contacts commonly determined the need for a visit to the general practice. The documentation included the advice given, whether further telephone contact was necessary and in the preparation of an individual for a GP appointment, whether or not an appointment had been made.

Telephone contacts

Practice nurse initiated

Practice nurse participants all described initiating telephone calls to the individual. These were often instigated from a recall list (as described under 'a system of recall'), or in a monitoring type role to see 'how they were doing', or in the provision of test results. Additionally the call may have been in response to a telephoned medication request by the individual taken by administrative staff. As an example regarding general monitoring telephone calls, Helen described her telephone contact in the context of contacting individuals after a death in the family, which she perceived as helpful.

I usually use the MedTech diary for notes to myself to ring the family after 2 weeks, then maybe a month, then 6 months later again. It's just that kind of "how are you doing?" because they're not going to ring you to say "I'm feeling sad". It's actually quite helpful, they get it from their family and friends more often but to get that. (Helen, line 797)

While most practice nurses described initiation of telephone contact with individuals regarding test results for ongoing monitoring of chronic conditions, some described rules within their settings which limited these calls, prohibiting them from giving results over the telephone. In this situation the nurses describe providing an interpretation of the individual's results, and communicating to the individual whether they needed to see the GP or not.

People ring up looking for blood results and things like that, our policy is that we don't give results over the phone, so I can say to them, well look you either need to or you do not need to see the Doctor, but I can't give you the results. (Angela, line 104)

This appeared to be a code that meant that if the test results were abnormal, you needed to see the GP, and if you didn't need to, the results were possibly normal. Individuals were thus denied access to their results over the telephone, and the practice nurse was once more preparing the individual for a general practice visit. The reason for this was cited as the risk of disclosing information to the incorrect person as it was potentially difficult to confirm identity across the telephone. In contrast some practice nurses described occasions where they considered it was inappropriate to initiate telephone contact with individuals regarding their chronic condition, and instead used postal methods of communicating these results to the individual.

If it's a follow-up on cholesterol, ringing people at work (to tell them not to eat too much butter) is not a good idea so we send them a letter that

we generate stating what their test showed, a copy of their results.
(Helen, line 703)

This example does raise the question, however, around whom the investigation results actually belong to, as it is suggested that the individual should theoretically own these or at least have reasonable access to them.

Facilitation of repeat medication prescriptions

All participants described a key role of the practice nurse in the coordination and provision of repeat prescriptions for individuals, including those with chronic conditions. These were commonly telephone requests, with many of the participants describing a link between the presence of a chronic condition and the requirement for ongoing medication. Each also described a complex process associated with an individual on regular medication requesting repeat prescriptions from the general practice.

We'll look in the client notes for when they were last given that medication. We would look at the recalls to see if they were overdue for any specific tests, blood, x-rays etc. We'd also flick through our daily records to see whether there were any changes of medications and if they actually needed a follow up with the GP or the Practice Nurse. Someone with cardiac or on hypertensive medication needs to have their blood pressure done six monthly. In a year timeframe, one of those blood pressures needs to be done by the GP, the other by the practice nurse. The one with the GP generally is their annual check. (Dianne, line 452)

The identification of recalls due, such as monitoring blood tests was often undertaken at the same time, apparently providing a prompt to the ongoing monitoring that occurs with individuals with chronic conditions.

In response to the medication requests, the practice nurse undertook to generate the appropriate monitoring test forms, communicating to the individual the need for follow up at the general practice if necessary, and generation of the prescription once all of the checks were complete. The ultimate decision regarding the provision of the repeat medication was made by the GP.

I'll check when they last had a script, what bloods are needed, when they last saw the doctor and I may make a forward appointment. I put the script out for the doctor to sign as long as he's happy with the patient's attendance and blood results, he will say if not. (Jenny, line 338)

The process of medication renewal had become a role central to the general practice system of checking and monitoring individuals with chronic conditions. It served a purpose within most practices as an opportunity to review the

individual's attendance with the general practice, and the initiation of follow up visits primarily to the GP, and less commonly to the practice nurse. No participants described how the individuals were informed of the procedure for gaining of repeat medication prescriptions.

The system of 'Recall'

As an integral aspect of preparation of the individual for an appointment at the general practice, all of the practice nurse participants described a complex system of identification and follow up of individuals with diagnosed chronic conditions known as 'recall'. All participant settings utilised Medtech 32, a computerised system, and the predominant software package used by General Practices in the research area, with all nurses describing involvement in the system of recall.

Recall is where an individual's medical clinical record is assigned an electronic reminder regarding a particular task, such as a blood pressure check, with an assigned timeframe. The recall can be viewed at any time a general practice team member is within the individual's clinical record, or can be generated onto a practice wide list for a specific time frame. The recall is one method of ensuring ongoing monitoring is achieved, such as the blood test monitoring of diabetes.

The practice nurses consistently described the procedure of recall to be the domain of the nurse. Some practice nurses described initiating recalls according to predetermined timeframes, however not all practice nurses were autonomous in the instigation of recalls, with several describing the GP in the practice as the initiator and instructor of the recalls, determining if the recall ultimately needed to be implemented and used.

We have a recall system for each of the doctors and a nurse takes responsibility for that recall system... From there, when a person is identified and the doctor starts them off on a statin or another lipid lowerer, or they're started off on an anti-hypertensive we generate recalls from there and the nurse is responsible, and the Doctor goes through them once a month and invites the people to come in for their blood tests, their appointment or whatever it is that they need. (Brenda, line 361)

One purpose of recall was to ensure a follow up visit occurred, often with the GP. The process of recall occurred typically by printing off a recall list, either retrospectively, or prospectively, and could contain anything from a week to a

months worth of recalls due. The majority of the practice nurses described a complex system of checks that were executed in generating a recall.

So, we have a recall system, we get a printed list each month which would include when someone was due for a diabetes check and the practice nurse who is going through that list would then generate a lab form. They would check that some of the tests, they hadn't just had, because there is no point in duplicating, ensure that they are all on the form and we have a generic letter that we attach to the form explaining the free annual check, the timeframe and if they could make an appointment a few days after they've had the blood test. (Dianne, line 179)

A further use of the recall was described by Dianne as a way of prompting follow up for individuals she was not familiar with, and for young people she perceived to be too busy to remember a scheduled follow up.

A young person, you know what they are like, they have so much going on in their lives and they have good intentions to ring but I'd probably put a message in my task bar to follow up with them. (Dianne, line 345)

One practice nurse described the recalls as 'tasks' she needed to undertake, often without the knowledge of why she was recalling the individual. She also identified a need to have an understanding of why the recalls were being implemented.

Usually quite task orientated from the doctor's request, like someone with hypercholesterolemia and heart disease, it will be in response to a blood test they might have had, that the doctor will initiate a recall of their blood test. The nurse will do the task, of the blood pressure at the doctor's request, or recalled blood tests. (Claire, line 91)

The use of the recall system was also linked in several cases to the initiation of a classification, or nomination of a medical diagnosis to the individual.

Yes, now that we have that structure [Free Annual Diabetes Check] in place it's still worthwhile using it. Prior to when the Trust [Diabetes Trust] came into place there wasn't that structure and a lot of those people weren't on classification. We didn't even know who they were.

Can you describe what the classifications are for?

That's the term used in the computer programme which pertains to the actual disease. (Fiona, line 484)

Some practice nurses also described utilising these classifications to generate 'query builders' to identify individuals by categories such as recalls and medications. This further enhanced the practice ability to identify individuals with chronic conditions. This was seen as an advantage with the upcoming use of 'Care Plus' within the practice settings in the research area.

I should imagine a query builder around medications and around screening entries would hopefully identify those people [with chronic conditions]. (Elaine, line 491)

The recalls were entered by several processes to include both the point that the individual enters the practice computerised system, and when the individual came to the attention of the practitioner either at a visit or between visits. Commonly this was on receipt of a diagnostic or screening test result, or letter from outside of the practice, necessitating a follow up recall. Several practice nurses described a process whereby upon being registered with the practice, previous clinical notes of the individual were screened by the practice nurse for the individual's medical history, this being entered onto the computerised system, generating recalls that were either automatic or entered manually.

Now we've got some things that happen automatically when a person registers, for instance the flu vaccine, tetanus vaccine comes up. Screening; over 50 for glucose and lipids comes up automatically. We haven't put PSA [prostate specific antigen blood test] on there because that's still a test that there's a lot of query around. Mammograms, cervical screening and all the childhood immunisations, those automatically come up at the time the person's registered on the computer. (Brenda, line 292)

When new families come into the surgery we go through their medical history and if they do have diabetes, we check if they are in the area [geographical area] and have had a check, or if they're outside of the area we also put them on recall. (Dianne, line 147)

Additionally recalls were entered at specific visits by the practice nurse or GP to assist in follow up. The range of recalls described included many related to the ongoing surveillance of chronic conditions.

Blood pressures are done then, we put priority on their family history, what their risks are, make sure they have had lipids done etc. so we can identify risks. We have an alert system on the computer, at this stage the Doctor is trying to identify Maori males between 35 and 50 years of age, so they have an alert on their files to be pro-active to their risks. (Jenny, line 220)

So you would have quite a range of recalls around chronic conditions?

Absolutely, bloods, blood pressure, diabetes review different from the diabetes project, hypertension review template with chest x-ray reviews every 2 years etc. (Jenny, line 359)

The contact with the individual regarding the due recall occurred via a variety of methods to include a phone call, letter, or by notification of the GP at the time of an individual's visit to the general practice.

Regarding utilising the identification of due recalls to prompt the GP, several practice nurses described scanning the GP appointment book identifying the recalls due or overdue, in order to notify the GP of these.

Yes, the doctors aren't perhaps using it [computerised system] to its maximum in the sense that there is monitors and recalls, or with their consultation times. Sometimes it can be a bit of a nightmare to cover everything but at one stage when we weren't so busy, I used to look at all the doctor's appointments for the day and think "oh, they've got a recall to do" and remind them on the doctor's screen, but knowing that the doctor may not want to bring that up as they don't have the time. But to try and initiate something. (Claire, line 320)

We try and scan the doctor's appointment to look for people that are due for things. We do have alerts on our patients... We try to work as a team to catch people and there is nothing more frustrating when someone you have been trying to catch for 4 months has been in to see the doctor and you've been too busy that you missed them. (Greta, line 82)

Greta describes this scanning as a team activity contributing to the ability to keep up to date with things individuals are due or overdue for according to the practice recall.

The system of recall also affords the practice nurse a dual role in both watching over the individual with a chronic condition, and in supporting the work of the GP. Such described tasks as the checking of the GP appointment book for recalls due prior to, and when the individual comes to the practice, provide a level of support to the GP who, as Claire describes, may not be utilising the system to its potential.

Conclusion

Overall the practice nurse participants described a wide range of roles in the ongoing preparation of the individual with a chronic condition for an appointment at the general practice, with the GP or practice nurse. The role of telephone assessment and the giving of advice were described by many. It was evident that a main emphasis of these telephone conversations was the role of the practice nurse in the assessment of the individual's need to attend the general practice, and the provision of repeat prescriptions for regular medications. Additionally, the complex systems of recall and reminders served a prompt to ensure that

individuals were reminded regularly of the general practice recommendations around ongoing monitoring and surveillance of their diagnosed condition.

Both telephone contacts and recall systems were primarily described as the domain of the practice nurse, although both had controls in place whereby a level of consultation was required with the GP regarding content and outcomes of such contacts. The role of the practice nurse as an autonomous registered nurse was described by some (although not all), situated within the context of working within a general practice team. The following chapter will describe the second theme to emerge from the data of care provided by the practice nurse at the general practice setting, to the individual with a chronic condition.

Chapter 5

Care provided by the practice nurse at the general practice

Introduction

An area repeatedly described by the practice nurse participants was the provision of care to individuals with chronic conditions through visits at the general practice. This care was at times provided by the practice nurse independently, or as a precursor to the individual seeing the GP. Most participants described rules within their settings regarding the frequency of expected follow up of individuals with chronic conditions to the general practice, and additionally care may have been delegated by the GP to the practice nurse.

The practice nurses interacted with individuals with chronic conditions face to face, as planned visits when the individual had an appointment, and unplanned visits when the individual arrived at the practice without an appointment. The participants provided a large amount of detail regarding both the reasons for these visits and the care provided. This chapter will outline the care participants perceived they provided to individuals with chronic conditions.

Unplanned visits to the Practice Nurse

Though the individual planned a visit to the practice, from the nurses' perspective, visits without an appointment were unplanned, in that the nurse was not expecting them. Practice nurse participants described a wide range of presentations of individuals with chronic conditions to the general practice of an unplanned nature. These included visits for both acute and non-acute or routine reasons.

For acute visits the reception staff were usually the first point of contact for these individuals on arrival, identifying the need for an immediate assessment by a health professional. Typically the practice nurse was the team member who saw

the individual and undertook an initial assessment. This occurred regardless of what the nurse may have been doing at the time, and most practice nurses described a context of 5-15 minutes for these unplanned nursing contacts.

Certainly, the nurses tend to be who they [individuals presenting for acute reason with chronic condition] see first as they're waiting for the doctor. There is a perception that it's OK to interrupt a nurse's appointment but not a doctor's. (Elaine, line 397)

The commonly described reasons for acute visits related to cardiovascular events such as hypertension, chest pain and myocardial infarction; exacerbations of asthma and chronic obstructive pulmonary disease (COPD); and mental health emergencies. Less frequently described were visits related to pain, and diabetes. Within A & M facilities, where care was typically provided outside of normal general practice hours of 8am to 6pm, reasons for presentations were varied including respiratory exacerbations, acute pain, cardiovascular events, mental illness and chronic renal problems.

All practice nurses described responding immediately to the reception staff request, taking the individual to a room and conducting an assessment of the individual's health status. In many cases this included baseline observations, and a review of recent medication use. Angela describes her assessment regarding respiratory conditions.

If you have people coming in and they're needing spacers or they're coming in because they're breathless and they haven't used their inhalers, it's a case of "when did you last use your inhalers, what inhalers are you using and how often and are you actually using this one before that one or the other way round" because it's amazing the number of people who don't realise the importance of getting them right. (Angela, line 248)

A range of nursing assessment frameworks were described, with some described as 'informal'.

Acute patients are triaged as soon as they come in and we decide if they jump the queue. The very first quick assessment is "do they need to be seen immediately, as in chest pain" or "have they actually had this pain all night. It's [the assessment] probably informal but based on years of experience. You tune into those observations because you've been doing it for so long. (Helen, line 458)

And those assessments, I guess if you've had nursing experience already, those assessments are done very quickly. You look at someone and you know when they are unwell. It's a systematic approach I use from head to toe but it takes less than a minute. (Elaine, line 418)

Several nurses described creating a safe environment, allowing family/whanau to be present and not leaving the individual unattended in particular instances.

Yes, anybody with chest pain in the treatment room, we don't leave them.
(Greta, line 597)

Following assessment, most described initiation of emergency management if necessary, and contacting a GP immediately.

They [the reception staff] don't let them [individuals presenting with acute chest pain] sit in the waiting room. I put them straight onto oxygen, if they haven't taken aspirin I give them it and I'm giving them GTN [Glyceryl trinitrate] normally. If I think it's an emergency situation there are some keys on the computer that request urgent help and two doctors come running. (Elaine, line 391)

I take all the stats [baseline observations], different doctors have different ways of managing them and so you figure out what you want to do. But I immediately tell a doctor. (Ingrid, line 278)

A few nurses described having emergency management guidelines concerning nursing care of an individual with an acute presentation, or in the presence of guidelines not actually utilising them, necessitating GP input immediately.

We do have standing orders around administration for asthma medications [in an emergency] but we don't use them as we haven't all signed off on them. We tend to ring the doctors, I don't have any issue with ringing during a consultation, to ask for those medications. (Elaine, line 399)

In the context of one practice nurse who worked in an A & M facility, acute assessment by the practice nurse occurred with every individual presenting for a GP appointment, regardless of the reason for the visit, within a time context of two to five minutes. During the assessment this participant noted a need to establish a relationship, often with people who had not presented before.

I start my assessment with a history; where is the pain, how long have you had it, what sort of pain etc. Generally I go back and find out if this has been a long standing problem, nine times out of ten they do (which I discover when I ask what medication they take)... Once I have done all my observations I show the GP, who already knows they have someone waiting. They will come and assess the patient and I do an ECG. Once I've got that strip, I'll know if it's abnormal, I show the doctor and we'll go from there (Ingrid, line 274)

Ingrid described a complex interaction within a constrained period of time whereby she undertook a comprehensive assessment and determined a course of action in the preparation of the individual prior to seeing the GP.

Planned visits to the Practice Nurse

Participants provided a rich description of planned visits to the practice nurse of individuals with chronic conditions. These were visits through a booked appointment, which the practice nurse was expecting. Included were examples such as regular reviews or follow-ups, and 'nurse led' clinics. The nature of the visits varied in time allocated, care provided, and between more commonly described chronic conditions such as diabetes, and those less commonly described chronic conditions such as mental health disorders.

When the visit for a chronic condition with the practice nurse was for the individual to obtain a repeat prescription, most described detailed processes of assessment, medication review of therapeutic effects and side effects, and baseline observation recording. Dianne describes this within hypertension medications for a visit of an individual for a repeat prescription, including her assessment and consultation with the GP as necessary.

Generally, we would have a bit of a chat first [the practice nurse and individual], to see how they are overall. We do an assessment, we would discuss medication, whether they are taking them regularly, and if it's a new medication we check if they have noticed any side effects. We would ask if they have experienced dizziness, light headedness, palpitations etc. Probably the questions we ask would depend on the answers we get. If it's "no" then we won't drop down to the next level of a more in-depth assessment. We do lying and standing blood pressures. Also assess if there are any extraneous variables that may impact on today's readings, had they been racing around or been relaxed in the last 10 minutes? Smoking, huge meal etc? If there needs to be any intervention from the GP, such as the blood pressure's not acceptable or they are having side effects, or experiencing any symptoms, we would collaborate with the GP if they need to see them or we get them back in a little bit earlier for another blood pressure check. (Dianne, line 464)

A few practice nurses described a 'case management' approach to planned visits, with individuals being asked at the initial visit if they agreed to see the same practice nurse at follow up visits.

I also talk to them about case management and if they want to keep seeing the same nurse, because we all work part-time. I understand that people form relationships and we try to keep those relationships to where people feel they are working. (Elaine, line 64)

When considering the range of chronic conditions illustrated by the participants, this can be primarily described as two main categories to include common and less common chronic conditions, in accordance with the frequency of description of

these conditions. The practice nurses all provided a large amount of detail regarding the more prevalent areas as outlined in the background as key health priorities in the New Zealand context, related to diabetes, cardiovascular and respiratory diseases.

Diabetes

All practice nurses interviewed provided description of planned visits to the general practice of individuals with diagnosed diabetes. Several differentiated between Type 1 and Type 2 diabetes. Prior to diagnosis those individuals would commonly have had a visit to the general practice regarding symptoms, and have had diagnostic tests initiated. Initial diagnosis of diabetes was given by the practice nurse over the telephone in some cases, as previously described, or individuals were requested to attend the practice to discuss their test results.

Following a new diagnosis of diabetes, many nurses described the initial visit by the individual with the practice nurse, to consist of limited information giving regarding the condition and initial management. This was to enable the individual to begin to manage their condition.

Another sort of check [visit to the practice nurse] can be a new diagnosis, after being told by the doctor they can be feeling absolutely dreadful, so that's survival information, getting through the next day or two until we see them again, and knowing the signs and what to do if they're not well. (Elaine, line 170)

So as a first point of contact, they come in, and we go through the absolute basics, give them their homework to go through with their family. And come back with any questions. Interestingly enough, not many do, those books are fantastic and also get them tuned into some of the other diabetes contacts. (Helen, line 744)

The description of this giving of information by the practice nurse is further described in chapter six: "Giving of information".

Following the diagnosis and initial consultation, the amount of ongoing contact between the individual and the practice nurse varied. This ranged from regular ongoing care provided by the practice nurse to no further nursing involvement.

Sometimes I can see it's all information overload, and you wonder how they're going to get on [individual with newly diagnosed Type 2 diabetes]. I think it's important to somehow follow them up later on and that probably isn't done unless they turn up themselves. Like a man that turned up the other day, starving because he hadn't had his breakfast. He'd done it [a blood glucose test] right in the first place because I did his

memory [checked the memory on his glucose meter] on his glucose meter and he'd done it right anyway. (Claire, line 191)

Claire is describing the procedure in the practice where she worked, where individuals with newly diagnosed diabetes were seen initially by the practice nurse for health and lifestyle education, with no further follow up. In this practice the individual saw the GP for regular follow up related to medication.

In contrast, several practices described a process whereby the individual was invited to attend a series of visits with the practice nurse over a designated time period.

We do try and get them back weekly, initially, depending on what their individual needs are. Some people will link into organisations outside in the community. Such like the Diabetes Society that runs an 8-week education with people who are newly diagnosed. (Dianne, line 76)

I don't try to overload them with information and so what we do over several weeks is look at the information that's there, go away and put it into practice, come back with questions. We teach them to do their own monitoring as well, quite early on, because each of the food groups, as we know, will affect them in different ways and what's right for me, won't be right for them, and they're curious, they want to know what's happening to the food they're eating and what it's doing to their blood sugars. (Brenda, line 135)

These regular planned visits with the practice nurse were predominantly in the initial post diagnosis phase, although several nurses did describe individuals being encouraged to attend three-monthly reviews with the practice nurse.

Diabetics are seen every 3 months, when they are a new diabetic we spend quite a bit of time on education with them which at this time is free. Yes, once the doctor's done the diagnosis and a brief overview, then they see us, probably 3 times, by the time you give them their folder [of resource material regarding diabetes], explain that we don't expect them to know this and there's not going to be a test at the end of it, educate on meters etc... They are on recall every 3 months, once a year they get a free diabetic check, we try to get most people when they come tee'd up for their blood test for the next time so it saves them a trip in. They have a fifteen minutes appointment with the nurse. (Greta, line 106)

For a first visit it would a half-hour appointment, the patient would be identified and referred by the GP. They are picked up through the weekly recalls that we as nurses process, whether they are their three-monthly recalls for a blood test. The patient is sent a letter to say their blood test is due and the recommendation is to follow that up with the nurse the week after their test. Who will then discuss their results with them and any changes that could be made and will involve the doctor at the time of consult. So she's not stepping over boundaries but is involving the doctor.

It's getting them in and discussing their results in detail and looking at management. (Krista, line 67)

Within regular ongoing planned visits, some practice nurses described confusion over the role of specialist services and referral criteria to those services in their practice location, attributed to an environment of constant change. Some described the need for a clearer understanding of roles, lines of responsibility and accountability of health professionals with acknowledgement that there was the need for specialist services.

I'm a bit confused at the moment about just what they [specialist Diabetes service] do, because it seems to change regularly. I think it's an area that could be done better in this town. Not the actual doing of it but the understanding of who does what because the lines of responsibility at the moment are very unclear. There was a time when everybody got referred to (specialist Diabetes service) they started ringing back saying "no, you can do that" but we'll get that sorted, there are changes coming. (Helen, line 759)

The use of guidelines as evidence-based practice within planned care, was described by few, those doing so predominantly referring to the New Zealand Guidelines Group. Generally where guidelines were used, this was not structured or guaranteed by all team members. Elaine described her perception that the practice nurses were following such guidelines, but other practitioners such as the GPs, were not necessarily.

We do have some guidelines (New Zealand Guidelines on Diabetes Management) we don't have an algorithm at work, which we might need to address, about doing that screening entry, but the guidelines are there and we have all read them. So I base my practice on that but I don't have an algorithm that I can say the same practice is used throughout the practice. I could not guarantee that every other practitioner in the practice would be following that guideline because we don't have that set policy. I know that the nurses do because we talk about that. (Elaine, line 263)

Reference was also made regarding the presence of unwritten guidelines that the practice nurses were expected to follow.

There's an unwritten rule that people who have heart disease, because we have [multiple] doctors all working differently, some doctors want to review their patients every three months, six months or annually. So it is quite difficult in the sense that we're not always sure of what is exactly wanted, but as far as a nurse initiating any chronic care, we're not really. The nurse will do the task, of the blood pressure at the doctor's request, or recalled blood tests. (Claire, line 98)

Claire is demonstrating a concept described by several participants whereby working within a larger group practice provided specific challenges around the variation in practice and expectations of the GPs, and to a lesser extent the practice nurses. In considering individualising of care within evidence-based guidelines this nurse is describing the need to navigate within these varying sets of rules between the employing GPs.

The majority of the practice nurses described contributing to a “Free Annual Check” (FAC) funded by the MOH for individuals with diabetes. The practice nurse contribution consisted of a series of technical measures that were collected at the time and recorded into an electronic template which was sent to the local Diabetes Trust. Informed consent was gained prior to this. Several nurses viewed this as an ‘information and tick box collecting exercise’, although some did make a correlation between the data collected and the generation of local and national statistics around people with diabetes.

We are designated half an hour for the check, sometimes it takes a lot longer. And sometimes in those sessions it feels like a little tick box that you’re doing rather than what I perceive we should be doing. So it’s a matter of filling out a form with objective measures. (Dianne, line 116)

The Diabetes Trust free annual check, is standard, there is a form to fill out, a computer template now, and there are specific things that need to happen. Biochemical measures need to be noted from the labs, blood pressures, height, weight etc - physical checks. (Elaine, line 153)

Diabetes Trust have a set format, they like to receive specific information and the computer programme we use has set templates for this. We fill them in and retain the information, then print out a copy for the Trust. They then report back to us from those statistics. (Fiona, line 466)

The following table demonstrates the aspects of the FAC the practice nurses described undertaking:

Table 8. Free annual check components

Technical tasks	Additional aspects
<ul style="list-style-type: none"> ➤ blood pressure recording ➤ blood glucose monitoring results ➤ height measurement ➤ weight measurement ➤ reviewing and recording of blood test results ➤ medication review 	<ul style="list-style-type: none"> ➤ how the individual is ‘doing’ ➤ care options ➤ coordination of referral <ul style="list-style-type: none"> ○ dietician ○ retinal screening ○ specialist services ➤ identification of areas requiring

<ul style="list-style-type: none"> ➤ smoking status ➤ foot check (infrequently) 	<ul style="list-style-type: none"> improvement ➤ diet discussion and ‘negotiation’ ➤ exercise discussion and ‘negotiation’ ➤ foot care education ➤ medication discussion
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The majority of the nurses described initiating the FAC by sending a reminder letter with standard blood test forms.

We write a letter inviting them to come in for a free diabetes check... so the letter does that and says “can you please have your bloods done and then make an appointment to see the practice nurse and the doctor”. (Brenda, line 218)

Several participants noted that they had the skills to complete the entire FAC process if permitted by their GP employer to do so.

I do believe that the nurse is quite capable of doing the whole assessment without the GP unless there is an issue that needs medical intervention like change of medication. However, from a person who’s accessing that service it means it is free and they’ve had their free check so they won’t have to come back again and pay. (Dianne, line 197)

Meanwhile some participants identified a lack of confidence in their skills to complete all components.

At this point in time, there’s been some encouragement from a particular GP colleague, who thinks that the nurse should just be doing them [FAC] now. The basis of that could be financial, they’d still get the same income whether the nurse did it or he was involved. I think at the moment, that suggestion is a little bit premature on the part of the colleague who suggested it in that I don’t have a paper on diabetes, or something that says I’m qualified to do that. I could see in the future that it could work out, with the necessary education. But I think there would still always be people that need to see the doctor for purposes of medication changes or other problems that you’ve picked up. (Fiona, line 51)

Not all practice nurses described providing a consistent nursing contribution to the FAC, with one nurse identifying that the GP may decide to complete the FAC when seeing the individual for another reason. As a result the practice nurse input may have been reactive in nature, potentially limiting the nursing contribution.

Hopefully they arrive before their appointment with the doctor. But that doesn’t always happen. No. Because the doctors will get them into their room and then decide to turn it into their free diabetes check, and then expect us to quickly fit them in to do their weight, height and blood pressure and not even touch on anything. (Claire, line 665)

Some participants did describe a view of the FAC as beneficial to the individual, with many describing the utilisation of this check to discuss areas other than those

on the data collection tool. They provided rich descriptions of opportunistic use of the visit in order to gain the most benefit for the individual.

It should be the whole head to toes assessment, and it's also really guided, once you've got that data collection out of the way you can really focus on what that person has identified that they need more information on. Throughout the time you can throw in a bit of opportunistic stuff too, that you might not have picked up if you hadn't been sitting there for half an hour chatting with them. I think the relationship is really important and that the person can feel quite relaxed in admitting to stuff that they do, that they know they probably shouldn't be doing, and saying "well, that's OK" but looking at how they may be able to manage things a little bit differently. So if someone wants to know more about cholesterol the whole session may be set around this aspect. (Dianne, line 124)

Time allocated for the FAC ranged from 15 to 30 minutes with solo practice nurses noting that they may limit the number of FACs booked per day as this limited their accessibility to the general practice population. Those general practices that provided specific 'Diabetes Clinics' also provided set days available for the individuals to attend for their FAC.

After completion of their component of the FAC, all practice nurses transferred the individual to the GP, with varied communication with the GP prior to them seeing the individual. The GP role was generally described in terms of completing the foot check, and providing a medication review.

We would look at what medication they're on, and we would suggest to the GP, or if the GP was hesitant to making any changes, I would rationalise why I think they're needed. Most of the time the GPs really do listen to our expertise in that area. (Dianne, line 158)

Some described an absence of any method of communication or discussion with the GP. One did however describe documenting concerns.

See if they've got any concerns and document it for the doctor, then they go in to him for fifteen minutes. (Greta, line 133)

The provision of specific diabetes clinics was described by several practice nurses. These generally occurred on set days and consisted of individuals with diagnosed diabetes seeing an assigned nurse within a time allocation of 15 to 30 minutes. These clinics were utilised initially following diagnosis, to provide a number of visits to the individual, and in some cases were at no cost. The practice nurses who provided care in these designated clinics described many aspects regarding the management of the diagnosed condition. This is illustrated by Greta.

We talk about diabetes itself because you get all the usual questions. Some are really good, some are astounded and negative. We don't take the approach "this is the folder, follow this now". We talk about their diet and say "OK start this week by trying to cut out this and this. Next week add one more thing etc", because you can't change patterns of forty to fifty years over night. Most of them accept this but we had one lady that needed so much TLC. An educated, professional woman who was just in total denial even though her mother and grandmother had been diabetics. She hadn't seen the symptoms, I think she was in denial before she even came to see the doctor to have the blood tests. She's really good now, she's had a complete turnabout. They just need the encouragement that they are doing the right thing and when you say that, they feel a weight off their shoulders. (Greta, line 196)

The following table details the care provided by practice nurse participants in the diabetic clinics.

Table 9. Diabetic clinics

Technical tasks	Additional support aspects
<ul style="list-style-type: none"> ➤ feet checks ➤ medication review ➤ preparation for a GP appointment ➤ education on blood glucose monitoring 	<ul style="list-style-type: none"> ➤ education about what diabetes is ➤ diet assessment and discussion ➤ referral to specialist services ➤ checking attendance at specialist clinics ➤ coordination of recalls and blood tests

Participants overall provided a significant amount of description regarding planned care of individuals with diagnosed diabetes, primarily Type 2. This supports the national priority area of diabetes care, with the FAC as a primary means of provision of care to these individuals.

Cardiovascular conditions

Participants provided significantly less description of their contribution to planned visits with individuals with cardiovascular disease (CVD). This is despite CVD being the most prevalent common condition in New Zealand (MOH, 2004).

Two principal contexts were described to include regular reviews such as for hypertension (commonly linked to a medication review), and structured clinics where a designated practice nurse saw the individual with diagnosed CVD. This limited description was primarily provided by practice nurses who had expressed a

particular interest in the area of CVD. Elaine describes the complexity of the nursing role within a regular review.

I tend to start out with cholesterol or hypertension, and they are both quite similar management. I start by introducing myself and my ultimate aim is to get them comfortable enough to lie on the bed and talk to me because I want a good resting blood pressure. I have an agenda, and I have a little tick list which I use and some key words in the computer that prompt me if I haven't asked enough questions. I want to assess their diet and lifestyle. I do inform them that I'm not going to tell them off, I'm not going to get upset. I try to put them at ease and say that whatever information and treatment we give them does have to fit into the context of their lives and we can negotiate it. From there it is just an assessment and I take their blood pressure. If I get two consistently high readings, I inform the GP and advise the patient that this is a safety issue. I use the guidelines so I actually have got research to base that on. Then there may be follow up blood tests, perhaps an ECG or maybe they need to see the GP about medication. There is always follow-up even if it's only diet and lifestyle advice. Although the recommendations state a follow-up blood test (for a cholesterol level) in 10 years time, I offer them an earlier test so perhaps, 3 - 6 months then retest. A lot take that up now. (Elaine, line 345)

Within the structured clinics, Krista describes the provision of these by a designated nurse in her practice setting.

This is new to us and is run by the same nurse who has done post graduate papers in both diabetes and cardio vascular. It has only just started in the last few months and the patients are targeted the same way as in me going through the scripts. The letters are worded in a very friendly manner and she has had a very good response. The GP's will refer as well.

What type of things would she cover when she sees them?

What is hypertension, how your medications are working, lifestyle changes and living with it? She will do a cardiac risk assessment on them, we have a really good screening tool within the system that she utilises. She uses a template from [person] in [city]. (Krista, line 259)

Both of these examples provide evidence of the practice nurse working within a general practice team, with referrals both to and from the GP.

For those that described limited or no interaction in planned visits of individuals with CVD to the general practice, this was commonly related to the GP requirement to see the individual regularly, in line with repeat medication provision. Jenny describes her role in blood pressure monitoring when the individual attends for the recommended three-monthly appointment with the GP.

The doctor encourages them to come in on a three-monthly basis. Blood pressures are done then [by the practice nurse]. (Jenny, line 220)

The following provides a comparison of the care provided within the two described contexts.

Table 10. Comparison of care of individuals with cardiovascular disease between clinics and regular reviews

Nurse led Cardiovascular Disease clinics	Regular reviews (hypertension)
<ul style="list-style-type: none">➤ blood pressure review➤ Medication discussion➤ Risk factor identification➤ Diet assessment and discussion➤ Lifestyle assessment	<ul style="list-style-type: none">➤ blood pressure review➤ assessment of knowledge level regarding medication➤ assessment of information needs➤ identification of risk factors for CVD➤ diet advice➤ lifestyle advice

Largely nurses who described planned care around cardiovascular conditions showed a strong emphasis towards their perceived role as educator. See chapter six on giving of information for more description of the context of CVD.

Respiratory conditions

Overall the practice nurse participants also described providing less regular planned nursing care to individuals with chronic respiratory conditions, and as with cardiovascular disease, these planned visits occurred infrequently when compared to those for people with diabetes. The primary reasons for planned visits of the individual with the practice nurse were the technical task-teaching of peak expiratory flow monitoring (PEFR), and medication device use. This care was commonly directed by the GP.

I probably don't have as much to do with them [respiratory patients] as the diabetics or the heart patients because they are usually here to see the doctor. So unless I'm asked to do a peak flow, or a spirometry done, we would probably have that done once a year for CORD (chronic obstructive respiratory disease) patients. (Jenny, line 183)

I think asthma's the biggest example. I don't think that a lot of patients are taking it in, what the use of each of their inhalers, when some of them are carrying up to 3 or 4 inhalers these days, and they really have lost track of what they're all for. They are the ones I'd quite like to see come back in more often and have more formal asthma care plans for them. The doctors don't tend to give them anything written either. (Claire, line 262)

Often, it would be asthma that we would tend to get the patient through, and we would be teaching them the use of the device. And again I've mentioned to the doctors that if they felt confident, they could make that diagnosis, and spend less time with them and send them through to us to start from the beginning; what is asthma. And you quite often will try and do that, show them the diagrams and airways but again it's like assessing their knowledge or at times there's a change of device as well. You don't actually always get the whole picture, we're very task orientated. (Claire, line 290)

Jenny and Claire both described a desire to have more input into the care of individuals with respiratory conditions, recognising that currently both are working within a task and medication orientated context.

The following table shows a summary of the care typically provided by the practice nurse to individuals with chronic respiratory conditions.

Table 11. Care of individuals with diagnosed respiratory conditions

Respiratory conditions.	
<i>Technical tasks</i>	<i>Additional aspects</i>
<ul style="list-style-type: none"> ➤ PEFR monitoring ➤ Spirometry measurement ➤ Medication device demonstration and teaching ➤ Oxygen saturation measurement (less frequently) 	<ul style="list-style-type: none"> ➤ Acute triage of urgency to see GP ➤ Assessment of previous medication use (type, frequency) ➤ Education of device use

One nurse described an absence of utilisation of any written form of information or action plans, with another describing asthma as not a priority for the practice, with the initiation of a planned review following an acute exacerbation primarily with the GP, and less often with the practice nurse.

At times we'll initiate a review or something that needs to be done in a couple of week's time, but it's usually done with the doctor. Occasionally there's an odd patient that would come back to see a nurse but I can think of reasons why we don't proactively do a lot of things with say asthma or some other condition and that's because as a nurse you're spending all your time doing your immunisations, your other preventative checks so those things get put aside and you just react to them when things happen. (Fiona, line 81)

As a rationale for less contact with the practice nurse, most referred to lack of time, the improved management of respiratory conditions, and the role of education in this.

Asthma is much better managed than it used to be. We are not nebulising like we used to, not seeing the acute episodes because people are much better educated about managing it.

And what is your role in that?

We are involved in teaching the use of the inhalers and devices because when they get a prescription they are passed out to us for it. When people come in requiring acute services, we triage them and make the decision on calling the doctor in or not. We go through the quick assessment, we are not involved as we used to be and I think that's because of better medication management. The most input we would have is when people are needing too much [medication] and we will recognise [this] from the prescriptions.

So you are screening their use?

Yes, we usually ring and suggest they need to see the doctor. (Helen, line 864)

The prevalence of respiratory disease in 2005 was 4.8% in males and 3.6% in females (MOH, 2004), figures in excess of the prevalence for diabetes, yet practice nurses clearly did not provide care to the same extent as for individuals with diabetes. This could be related to the government objective regarding diabetes management and the introduction of the FAC, with the key role practice nurses undertake in this. A further reason for the limited nursing contact with these individuals was that the care of these individuals was described as being primarily related to medication management, therefore requiring GP involvement in the absence of nurses with prescribing rights.

It is apparent that these participants provide limited planned nursing care to individuals with diagnosed respiratory conditions within their general practice settings. The care described was centred on the provision of education around technical tasks such as inhaler device use, repeatedly focussing care on the role of medication in respiratory conditions. Ongoing planned care for individuals with respiratory conditions by the general practice was described as a lesser priority, due to time constraints on the practice nurse and perhaps the GP.

Frequency of follow up of individuals with chronic conditions and the practice response to individuals reluctant to attend

Practice nurses described complex guidelines within their practice settings regarding the expectations (as commonly determined by the GP) of the individual with a chronic condition regularly attending the practice for review. Rationale for the prescribed regular follow up varied.

We do have some [individuals] who think it's all a bit of a trick to get money out of them... but by the time you've talked to them about the professional accountability that a doctor has for prescribing and suggesting to them that "if there wasn't that level of accountability (and yes, you may be well and he may just give you the same prescription) but if there weren't all of those controls you could just buy your pill from the chemist. So they are actually asking a lot of him to write you a script sight unseen and what happens if you have a medical episode 3 months later and an enquiry shows you haven't been seen for 9 months" they usually consent then so it's all in the way you deal with it. (Helen, line 598)

Regular follow up was also described by Brenda as a monitoring function within a complex regime of expectations to be communicated to the individual. This monitoring consisted of expectations around regular blood tests, and visits to the GP and less often the practice nurse, again related to the provision of regular medication.

If I have concerns I do, but I think because we're seeing our diabetic patients on a very regular basis, those concerns are picked up earlier. If they've got heart disease we see them 3-monthly. There are some that are uncomplicated and so they would be 6-monthly, they'd have bloods as well but for the majority of them it would be a 3-monthly check.

And is that with you as the registered nurse or with the GP?

Probably more with the GP because we time it in with their medications too. What we've got are alerts on the computer and so when somebody rings up for a prescription it comes up with "needs 3 monthly appointment" so that alerts the receptionist. Our telephone message says "if you haven't seen the doctor in the last 6 months and you are on regular medication, you need to make an appointment" and we also pick that up if they haven't made an appointment when we do the prescription and leave a small note on it. (Brenda, line 309)

Further factors that contributed to the determination of the frequency of follow up included complex sets of rules often set by the GPs, and less frequently according to the practice nurses perception of the level of wellness of the individual. The nurses were often negotiating different sets of rules within their practice setting, as previously described.

Depending on how unwell they are, most people would be seen every 6 months. Some we want to see every 3 months. Different doctors have different expectations too, which can become very interesting when you're talking about expectations about normal blood pressures, cholesterols etc. when talking for one doctor to the next. (Greta, line 327)

Additionally follow up was described in many instances as being more frequent following diagnosis of a chronic condition, reducing in frequency as the individual felt more confident in their self management.

Newly diagnosed have a lot more to cover and they will certainly be screened more often, monitored and ongoing follow-up until they feel they are confident in their management. (Krista, line 106)

The regularity of prescribed attendance at the general practice ranged from three-monthly, to annually. Coupled with these expectations, was the complex schedule of requirements around the gaining of a prescription for regular prescribed medications as described previously in chapter four. A number of practice nurses described a particular response to those choosing to not attend the general practice for the recommended follow-up. These ranged from no further contact with the individual regarding the need to be seen, to practices denying the individual ongoing care such as repeat medication prescriptions for their chronic conditions.

When they ring we tell them that because their medication needs to be closely monitored every 3 months and we book them 3 months ahead when they come in. If they miss that appointment we send out a reminder letter, if they then ring for a prescription, they won't get it until they book another appointment with the doctor. If they miss that, because all the scripts come through me I say to the doctor that they have DNA'ed [did not attend] twice so he will not sign the next script until they have come in to see him. (Jenny, line 336)

There was further description that individuals often accepted the advice of the GP over the practice nurse regarding requests for follow up, and if a request letter was signed by the GP, individuals were less likely to question the request, and more likely to attend.

My personal feeling is sometimes a patient will accept it more from a doctor and although we don't like it as nurses unfortunately that is a culture. We do have a good response from our letters but if the wording is "your Dr requests" there is a better response. (Krista, line 210)

However the majority of participants did describe acknowledgment of the individual's need for control of self management, and choice around need for

attendance, secure in the knowledge that the computerised clinical notes system would alert them to non attendance at a later time.

We send the initial invite, we do follow-up, we have a system on the computer that will indicate if the patient hasn't been in. You can then invite again with either a letter or a phone call. It's encouraging them. A phone call can sometimes make or break it, it may be that someone is just not interested and we certainly are not going to pester them. (Krista, line 206)

Some practice nurses did concede that the general practice team did not suit everybody, and in one practice it was recommended that an individual not wanting to attend regularly accessed the specialist services in the area. This raises questions around referral criteria to specialist services for chronic conditions whilst ensuring access is readily available when required.

Delegated care to the Practice Nurse

Practice nurse participants described the delegation of care within planned and unplanned visits of the individual with chronic conditions to the practice nurse. Rationales for delegation of care ranged from the inability of the GP to provide the care due to lack of time, to the individual's inability to afford the GP consultation fee, hence the individual visited the practice nurse as an alternative.

There's room for negotiation if someone can't afford to see the doctor and has just seen them recently, the nurses can usually be delegated for something like a blood pressure review or something like that. (Fiona, line 108)

The requirement for three-monthly visits was also a precursor to delegated care, with the practice nurses providing facilitation of regular follow up of individuals, to see either the GP, or the practice nurse. Several practice nurse participants described a perceived gap in the care of some individuals due to the delegated nature of the nursing input.

The people with chronic conditions don't usually just come to see the nurse, so I think there's a big gap as far as nursing input is concerned with those people unless they're presenting with a problem and some part of their care or follow-up (which isn't that often) is delegated from the GP to the nurse to do something; organise home help. It is very much reactive (Fiona, line 219)

Following diagnosis of a chronic condition such as diabetes, and the individual receiving the diagnosis from the GP, care was primarily delegated to the practice nurse by the GP, with the practice nurse undertaking an initial 'education session'

or giving of information which is described in more detail in chapter six. Elaine viewed such requests to educate as an entry point to caring for the individual.

Usually we start that way e.g.; asthma or COPD [chronic obstructive pulmonary disease], we give education on how to use the medication and that's our entry into becoming involved. (Elaine, line 36)

The method of delegation ranged from the GP interrupting the practice nurse to delegate care at that moment, to practice rules around regular care of the individual with the practice nurse within agreed roles. Regarding delegated care, many nurses described 'doing what the GP requested', as the individual they were providing care to had an expectation this would occur.

Within the majority of participant descriptions, many technical tasks were delegated to practice nurses. Regarding the more common prevalent conditions of respiratory, diabetes and cardiovascular disease the delegated care was frequently to provide technical task-teaching, to the individual.

Describe for me the role you play with young children with chronic asthma

Very minimal, it would only be a matter of taking a peak flow. I do a bit of education on use of inhalers, spacers etc. (Jenny, line 204)

From presentation, people usually go to the Doctor first, to have their chronic/acute condition assessed. From there, depending on the condition, the Practice Nurses become involved in an educative way, usually we start that way e.g.; asthma or COPD we give education... It is my experience that I have not generally been asked to sit and discuss someone's concerns, or issues, or lifestyle, or coping management with them, regarding their chronic condition. I am asked to educate them on their diet or use of medications, or to take their blood pressure. (Elaine, line 34)

One practice nurse spoke around tasks repeatedly being delegated to her by the GP, with no context provided. She was often requested to see the individual without access to any clinical notes, or rationale for the task. When this occurred communication did not take place between the GP and practice nurse regarding this delegated care.

Sometimes the doctors will try and do a verbal hand-over with the patient that's just come out of their room but sometimes that can't happen. They might just have "check BM stick" on the note. So that could be difficult, because if you look at their notes they haven't had time to write it up yet, and you're thinking "are you checking it because they've had a high day, or are they diabetic, or infection?" (Claire, line 421)

Within the Accident and Medical facility, individuals were also usually referred back to the practice nurse by the GP, to provide technical task-teaching and interpretation of what the GP had said. This was undertaken in an effort to ensure individuals were able to continue self management at home.

But if they stay in the cubicle I get to see them the whole time, as well as other patients. When the doctor goes back in, I go with them. I make sure the patient can understand what the doctor is saying, and remind the doctor to speak at their level. Once the doctor has finished and I have a full picture, I make sure the patient has understood it all too. (Ingrid, line 189)

It's one on one, or the whanau as well, and I make sure I speak to the patients and the care giver or the supporters. Make sure they know they need to follow-up with their own GP. Make sure everyone there knows the instructions and why they were given and the possible outcomes of all those pieces of advice. I like to make sure the patient is equipped and leaves with the structure of support in place. (Ingrid, line 198)

Follow up of test results for individuals with chronic conditions, including recalls, such as cardiovascular risk assessment, was also delegated to the practice nurse in most practice settings. As an example regarding CVD risk assessment, the practice nurse commonly calculated the risk of the individual based on cholesterol level results, blood pressure recordings, smoking status and family history, and transferred this risk calculation to the GP via the computerised system. However several practice nurse participants did describe occasions where the GP altered the risk assessment rating, making the practice nurse's assessment meaningless.

So when these results come back in, the doctors look at them, we file the ones not needing further action, but the ones in need of action come through to the nurses via the computer. We look at them and it is largely a nursing decision about what you rate the person as, perhaps their cardiovascular risk you would rate at 10% and recommend they see the practice nurse for cardiovascular risk assessment and diet and lifestyle advice, then we forward it back to the doctor with the recommendation and they may change things. (Elaine, line 243)

In this context a delegated task was undertaken with no assurance that the practice nurse role in determining risk level and recommendations, according to the guidelines, was acknowledged or utilised.

Conclusion

The practice nurse participants provided varied description of a range of roles associated with face to face visits by individuals with chronic conditions to the practice nurse. In contrast to the theme in the previous chapter, of preparation of the individual for an appointment at the general practice, the practice nurse role with individuals within planned visits appears to be more autonomous within the general practice team environment. While some did describe delegated care as being clearly directed by the GP, many provided descriptions of innovative and carefully planned care in response to the individual's needs at that time.

The repeatedly described emphasis on conditions such as diabetes reinforces the national priority placed upon these within the primary health care environment. Specified nurse-led clinics offered to individuals with certain conditions such as diabetes, provided a level of consistency and structure to the nursing care provided, although most participants described an absence of consistent use of evidence-based guidelines within their practice. It was, however, somewhat surprising that the more prevalent chronic condition priority areas of cardiovascular and respiratory disease appear to have a lesser priority (being primarily determined by the employing GP) in the general practice context although this appears to be currently linked to medication management and the need for the GP to prescribe.

A lesser amount of face to face care provided by practice nurses for individuals with commonly described chronic conditions such as respiratory and cardiovascular disease, chronic pain and mental illness, appears to be due to less formal organisation of this by the general practice team. This, coupled with the presence, primarily in group practice situations, of a range of expectations and rules around the ongoing clinical care, provided a somewhat disorganised picture of the care commonly provided to these individuals.

The following chapter will outline the third and final theme of the giving of information by the practice nurse to the individual with a chronic condition.

Chapter 6

The giving of information

Introduction

The giving of information was repeatedly described by the practice nurse participants in the care of individuals with chronic conditions. It was therefore a common theme that emerged from the data analysis, as an action that all practice nurses undertook. This perceived transfer of knowledge to the individual and their family/whanau occurred on numerous occasions, during both telephone calls, and face to face consultations with the practice nurse. A variety of methods including verbal advice, written documentation and advice regarding additional sources of information were utilised. This chapter will outline this third theme as described by the participants.

Why does the practice nurse give information?

The practice nurses described varied rationales for the role of giving information to the individual. Regarding the perceived individual's 'need' for knowledge, one practice nurse gave the following description of her reasons for providing information.

Enabling patients to monitor and recognise and respond to worsening symptoms, getting them back on a regular basis and being able to quickly recognise when they are in trouble... They (the patient) need to know what is wrong, what's not right about things. (Angela, line 546)

This appears to be related to the individual's level of self-care, and the practice nurses' perception that giving information will enhance this.

The majority of the participants described the role of educator and information giver as largely being the domain of the practice nurse.

A huge part of our practice, mainly to do with patients but also educating our own staff... It's a huge part of our role, in every aspect of our nursing practice we are educating in some way, every patient we see. (Krista, line 136)

Krista describes her support role in information giving, responsive to the limited time context the GP works within.

The clinics are there to back up the GP's consults. My belief is they don't have the time to sit for half an hour and give the information required. (Krista, line 158)

Practice nurses appeared to utilise a range of opportunities to give this information. Opportunities were taken during tasks such as blood pressure monitoring.

It's opportunistic to bring up quite a lot of things with people, because they don't know what their BPs [blood pressure] should be, I think it's quite key that people should be told or have explained to them what's the optimum for them, they often don't know that... We need to be taking every opportunity to do that. (Claire, line 114)

On these occasions the practice nurse is describing both her perception of the type of information the individual needs to be given, and furthermore the necessity to utilise any opportunity to undertake this.

The repetition of information given was described by several practice nurses, and appeared to provide a method of reinforcement to the individual.

Sometimes we have people that have been diabetics for years, but we might still ask them "would you like one of the folders? There might be information there that can bring things up to date for you" (Greta, line 179)

In an attempt to validate the perceived individual's need for reinforcement of information, one practice nurse described the 'recapturing of understanding' of the individual within the context of a diagnosis of diabetes.

Even if the person has had diabetes for ages, they may not really still understand what it is. So it's like recapturing what the understanding is and how they need to look after themselves. Just going through the basics, that we sometimes take for granted that they already know. (Dianne, line 141)

This perspective appears to encompass repetitious giving of information to the individual, with an underlying assumption that they may not have an acceptable comprehension. The individual's level of understanding appeared significant to the practice nurse.

With booked consultation times of 5 to 15 minutes, the participants described constraints to the amount of information they could provide. Additionally the

contact with the individual immediately following diagnosis, or during an acute presentation to the general practice, was often accommodated immediately, regardless of the practice nurse's already allocated workload. In one example the individual was referred by the GP to see the practice nurse immediately, needing to be accommodated within her workload at that point in time. However the limited time available to her resulted in a restricted amount and type of information she could provide at that visit.

The GP would probably go through what they've got but it's usually our responsibility to do the dietary and we wouldn't have time to cover the exercise or all the blood tests and what they mean. It's time consuming, a big area to cover. (Claire, line 199)

The potential role of giving information was described by many participants as much larger than it was enabled to be. This again frequently related to constraints of time.

In the real world we can't always give the people the time that they need. General practice unfortunately has time constraints for some of those routine chronic cares, particularly diabetes. (Helen, line 737)

Some participants described attempts to gain a wider role in information giving with individuals with particular conditions such as asthma and COPD. For these conditions the role of the practice nurse was education, primarily regarding the use of medication devices such as inhalers. For some, this role appeared to be related to the GP perception of the practice nurses' ability.

I've mentioned to the GP that if they felt confident they could make the diagnosis and spend less time with them, and send them through to us to start from the beginning; what is asthma, and you quite often try and do that, show them the diagnosis and the airways, but again it's assessing their knowledge or at times there's changes in devices as well. You don't actually always get the whole picture, we're very task orientated. (Claire, line 278)

Identifying alternative sources of information for the individual to access was described by many of the practice nurses. This was encompassed as a further reason for giving of information as a 'helping role', perhaps with the underlying assumption that the individual may not attempt to gain information from sources other than the general practice.

Yes I try to do something to help, or suggest where they can go [for information] for help. (Fiona, line 399)

The provision of ongoing support was also described as a purpose for giving information to the individual with many practice nurses indicating their availability to the individuals, either in person or over the telephone.

Hopefully I try to be a support person who they can come to if they have questions... so I say to all my patients if you do have any questions please either ring or pop in. (Jenny, line 60)

There are a lot of people who don't need a lot of time, they need the nutshell information, they need the talking and the supporting and knowing we're here for a phone call. (Helen, line 737)

At initial diagnosis of a chronic condition

The majority of the practice nurses described the GP giving the initial diagnosis of a chronic condition to an individual, followed by referral to the practice nurse for 'education' either immediately, or at a later date. The GP may have, in some instances, given an amount of information at this time.

She's one of the at risk group for it [diabetes] so we did a test while she was here and found she had a high glucose. He [GP] told her she had diabetes, he gave her a small amount of information and she's coming back to see me again next week. (Brenda, line 122)

Alternatively some practice nurses gave the diagnosis of a chronic condition to the individual over the telephone, inclusive of information giving, as directed by the GP.

A blood test will reveal a raised glucose and we get a note "diabetes tell patient". I ring the patient and say 'we've got your blood test results back and they do need some discussion, is this a good time for you?' If so I give them a nutshell version and make an appointment to go back through it. (Helen, line 706)

Following the giving of the diagnosis, the practice nurse was often the first planned point of contact for the individual regarding their chronic condition.

So as the first point of contact they come in, we go through the absolute basics, give them their homework to go through with their family, and come back with any questions. (Helen, line 709)

Many of the practice nurses acknowledged the impact of a diagnosis of a chronic condition on the individual. This appeared to be subsequently associated with the practice nurse limiting the amount of information given to the individual at the time.

They are a bit shell shocked when they [individual diagnosed with diabetes] first come in. (Krista, line 119)

I give them very simple basic information about it because it's quite a shock to them. (Angela, line 273)

Survival information, getting them through the next day or two until we see them again. (Elaine, line 173)

One practice nurse described her response to a request by the GP to educate provided primarily to meet the individual's expectations at the time.

From there I do what the doctor has asked, because the patient is expecting it, but I also say we need to educate. I demonstrate about this.... (Elaine, line 40)

How the participants' day was organised appeared to influence the type of information given to the individual at diagnosis. Those working within designated clinics such as Diabetes Clinics, described a systematic approach to the type of information they communicated at this initial contact. This commonly included explanations of the pathophysiology of the condition, action of medications, basic dietary changes, and technical task-teaching such as blood glucose monitoring.

It was a matter of sitting him down and explaining this is what's happened within your body and this is what you need to do with our assistance to make changes. It was a matter of giving him the basic, 'what is diabetes' these are the tablets the doctor has given you and this is how they are going to work, we need to look at basic dietary changes, I didn't go into any detail, and talked of blood monitoring. (Krista, line 125)

There was limited description of assessment of the individual's current knowledge level or life experience of the particular diagnosed chronic condition by the practice nurse.

Table 12. Comparison of conditions and type of information given at diagnosis according to the structure of care

<i>Diabetes clinic</i>	<i>Diabetes Non clinic</i>	<i>Cardiovascular clinic</i>	<i>Respiratory</i>
<ul style="list-style-type: none"> • Causes • Pathophysiology • Medication actions • Dietary changes • Technical tasks teaching- blood glucose monitoring 	<ul style="list-style-type: none"> • Causes • Basic information • Survival information • Dietary modification 	<ul style="list-style-type: none"> • Medication • Exercise • Dietary advice • Risk factor calculation 	<ul style="list-style-type: none"> • Causes • Pathophysiology (infrequently) • Medication actions • Technical task teaching- Inhaler device & peak flow monitoring

Ongoing giving of information to the individual following diagnosis

The participants provided varied descriptions of ongoing information giving to the individual with a diagnosed chronic condition. Diabetes was the foremost chronic condition described in which individuals had planned ongoing visits with the practice nurse involving information giving. A range of chronic conditions were described, with none having the extent of processes associated with the giving of information as with that of the individual with diabetes.

All participants described contributing to the Free Annual Check (FAC) provided to individuals with diagnosed diabetes (as described in the previous chapter) with a role of information giving to the individual. This generally encompassed areas that the practice nurse deemed needed 'improvement', such as blood test results, and going through the 'basics again'.

You do have a systematic way in your head. Even if the person has had diabetes for ages, they may not really still understand what it is, so it's like recapturing what the understanding is, and how they need to look after themselves, just going through the basics, that we sometimes take for granted that they already know. (Dianne, line 142)

The information given by the practice nurse at the FAC may have been previously imparted to the individual, appearing to provide reinforcement from the practice nurse's perspective. Practice nurses also described taking the opportunity during other planned visits to give information. Regular visits for CVD were an example where practice nurses described such opportunities, with approaches to include having an 'agenda or tick list' to prompt the nurse.

I tend to start out with cholesterol or hypertension, and they are both quite similar management. I start by introducing myself and my ultimate aim is to get them comfortable enough to lie on the bed and talk to me because I want a good resting blood pressure. I have an agenda, and I have a little tick list which I use and some key words in the computer that prompt me if I haven't asked enough questions. I want to assess their diet and lifestyle. (Elaine, line 345)

CVD care was primarily described as 'GP led' by those nurses who recalled this within their interview. The practice nurse role as giver of information was primarily to contact the individual, often following a screening test such as a cholesterol level, and in addition within the context of providing repeat prescriptions for medications, and blood pressure monitoring. The information given within these contacts was often impromptu and opportunistic in nature.

In contrast, a practice nurse providing care to individuals within a designated Cardiovascular Clinic described a structure to the information she provided to include a description of what hypertension was, medications, lifestyle changes, education and a cardiac risk assessment of the individual. Overall the giving of information to individuals with cardiovascular disease was more likely to occur within the context of a designated clinic, than within impromptu visits to the practice nurse.

In considering the transfer of knowledge via information giving, variation in literacy levels and learning styles of the individual were acknowledged by a few of the practice nurses, however this was not described as the primary reason for the use of additional resources such as a written resource.

You need them on site to work out their learning needs. Pamphlets might just be hopeless for some people. (Claire, line 150)

To supplement verbal information given by the practice nurse, written resources were provided in a number of instances such as with diabetes and lipid education. The provision of a written resource of information to individuals diagnosed with diabetes was routinely described by the practice nurses participants. This was within the context of adults diagnosed with Type 2 diabetes. The resource was provided by the local Diabetes Society (Diabetes Trust) and described as a 'fabulous resource' by several. In some practice contexts the written information was the sole information given to the individual upon diagnosis of diabetes. This written diabetes resource was often given with an explanation and one practice nurse described how she communicated her expectations regarding the resource.

When they are a new diabetic we spend quite a bit of time on education with them... by the time you give them the folder, explain that we don't expect them to know this and there's not going to be a test at the end of it. (Greta, line 112)

In some practices the participants may not have undertaken initial education around diabetes with the individual, as they were referred to another nurse within the practice. Greta describes how this occurred within her practice.

They would hand them [the individual diagnosed with diabetes] the folder and make an appointment for when either of one of us diabetes nurses are back. (Greta, line 827)

In this situation the presence of a designated clinic limited the amount of information a particular practice nurse gave the individual at diagnosis, requiring

the person to then attend a designated clinic at the practice. This can however be viewed as cognisant of the shock of a new diagnosis and the risk of information overload, allowing for the practice nurse(s) with a particular interest in diabetes to provide the care.

At subsequent visits the practice nurse may attempt to evaluate the information the individual has gained.

We ask what they understand of what's been said etc, do they have any questions, have they looked through the resource folder we gave them. (Krista, line 200)

Further written information provided by practice nurses included pamphlets for individuals with raised cholesterol levels. Several practice nurses described a reluctance to give any information over the telephone regarding topics such as raised cholesterol. In these cases they utilised a system of posting a letter with the blood test results enclosed, explaining the results with the inclusion of a pamphlet on the topic if for a new diagnosis. This letter invited the individual to phone and speak with the practice nurse if they desired. Helen describes an example of responses to the letter.

Some ring offended and say' "I never eat butter and I always drink trim milk, how could this be? Was there a mistake?". (Helen, line 677)

The individual may not have been accepting of an approach that appeared to take a population focus on risk assessment, without actually making an individualised assessment first. The individual as a result may have thought the information was irrelevant to them personally, or they may not have been able to read or understand the information.

Consistency of information was further supported by organisation of care described as "case management", detailed by one nurse as enhanced by continuity of care.

Often the people that I manage (mainly cardiovascular) and ask them to speak with me because sometimes they get differing information, not that it's actually different, but it's just presented differently. (Elaine, line 307)

In this context the practice nurse was describing a belief that the information that was given to the individual needed to have a degree of consistency to enhance the knowledge transfer.

Information giving as part of the care of the individual with an acute presentation of a chronic condition

Within acute visits regarding chronic conditions, the type of education or information given by the practice nurse appeared to vary according to the size of the practice, the time available, and the knowledge level of the practice nurse.

For the practice nurse working within the Accident & Medical facility, it was routine that she saw all individuals presenting for a GP appointment, to conduct an initial assessment. The individual with the chronic condition may have been seen by the practice nurse both before the GP assessment, and following. The practice nurse described the aim of this initial assessment as attempting to gain an understanding of the knowledge level of the individual, and following the GP visit, as information giver, in acknowledgement that an alteration of medication was often involved.

If there has been any change in medication and the patient hasn't been sent directly out (home from the GP) I'll make sure they understand how much to take, when to take and why it's happening. (Ingrid, line 338)

This appeared to be occurring in an opportunistic rather than a planned way aimed at providing a check of the information that the individual had been given by the GP, and their understanding. This also acknowledges that the information given by the GP may be complex, requiring the back up of the practice nurse to confirm the individual's understanding. It also illustrates the role the practice nurse may take in overseeing the work of the GP, not necessarily being known by the GP at the time, for the benefit of the individual.

Generally the practice nurses described information giving in the acute situation to be related to technical task teaching such as inhaler device use for respiratory conditions, or blood glucose monitoring for individuals with newly diagnosed diabetes.

Practice Nurses' perceptions of their knowledge base, and educational preparation to provide care to individuals with chronic conditions

The practice nurses' knowledge of varying chronic conditions appeared to influence their level of confidence in interactions with individuals with certain

chronic conditions. Overall most participants expressed confidence in their knowledge and ability to provide information to individuals within the most prevalent chronic conditions of diabetes, cardiovascular and respiratory diseases.

I'm probably quite well enough qualified to do it, I've done the resource nurse programme at the [DHB provider] and at the beginning of this year I did the diabetes paper at [education provider], so I'm probably reasonably qualified to do it. (Angela, line 281)

It's having the confidence as a nurse, and the knowledge of that disease and dealing with it everyday. We have both the knowledge and the skills to do it. (Krista, line 138)

Because they're familiar [prevalent chronic conditions] you feel more inclined to be involved, also with the prevalence of those diseases, they make up the larger percentage of your patients that have those more common things. (Fiona, line 427)

Many participants described the process of knowledge acquisition regarding chronic conditions as a lifelong process. One nurse described the value of undertaking education at a post graduate level.

I'm undertaking a Masters of Nursing, and that's actually given me some much greater skills with an assessment paper, all those things should give you a greater awareness and ability to do those checks... I come from the old school of nursing training, at the hospital, and the basics for us were learning the bones of the skeleton, the muscle groups and we learnt as we went really. So the best thing that I've ever done was carrying on to do some post grad study. (Brenda, line 278)

Identification of the knowledge required to competently provide information to individuals with chronic conditions appeared to be self initiated with no identifiable process indicating the level of knowledge appropriate for the practice nurse.

There's updates on diabetes, respiratory, we've just had a hypertension update, I try to go to those, they're mainly evening meetings so I try to balance those too. Those areas I know I have to up-skill in or those I haven't done for a while, I make sure that I go to. So I will never have learnt enough, I'll never have the most knowledge but I try and make sure I'm up to date. (Brenda, line 560)

Yes I feel that I've had access to it [education], but because I have gone out and sought it. If you are not the sort to source it yourself then you might just be feeling you need more. (Elaine, line 526)

However, having knowledge regarding a particular chronic condition did not necessarily equate to the practice nurse feeling able to utilise this in giving

information to the individual. When considering knowledge level and confidence, one practice nurse described the isolation in which new information may be gained by practice nurses.

We haven't really had good communication lines with the doctors, we haven't really had formal education together as such, and I know there's a frustration there that we should be doing that because there's always this need that nurses want endorsement that they are doing it right for themselves. (Claire, line 307)

Within this description the practice nurse is reflecting her perceived need to communicate updated knowledge to the GP, in order to gain the GP approval or endorsement of this updated knowledge. This may result in an increased ability for her to apply this to her nursing practice.

One practice nurse described frustration at having knowledge in a particular area, but being restricted in the application of this, due to employer constraints.

I have done workshops in wound care, ulcers etc. One of the biggest frustrations as a practice nurse is knowing what's out there and knowing what your bosses will buy... We would probably suggest a referral [for care outside of the setting] to the GPs more often than we used to because of the range of product they [wound care nurse and district nurse] can get. (Greta, line 654)

In this case the employer provided constraints to the choice of wound care products the practice could purchase, resulting in the practice nurse being unable to utilise knowledge in the care of the individual with a chronic condition. This therefore necessitated referral of the individual outside of the practice.

Access to a variety of ongoing educational opportunities was described by many of the participants, and this appeared to contribute to both the confidence and perceived ability to provide ongoing information to the individuals. However many practice nurses did describe areas of specific interest which influenced their choice of attendance at educational sessions.

Opportunities for education are improving all of the time, to the point where you have to choose, because there's only so much you can do... to be honest I haven't done as much in the respiratory area as I should have... I'm not as interested in lungs as some other things. (Helen, line 808)

I attend a lot I believe you can't get enough... I tend to look at the areas of what I'm interested in... everything is changing, you have to keep up. (Krista, line 388)

The following table describes the educational opportunities described as being undertaken in the few years previous to the research by the participants.

Table 13. Education and professional development

TYPES
Diabetes Trust education
Ministry of Health conferences on chronic conditions
Tertiary provider undergraduate paper in Diabetes
Local College of Practice Nurse section updates
Regional nurses hui
Mental health education by local Management Service Organisation
Postgraduate papers in Masters of Nursing

Self directed sources of ongoing education and information were also described.

I use the internet a lot, I go onto the Guidelines Group, I read extensively too. (Brenda, line 566)

Regarding less commonly described chronic conditions and information giving, the majority of practice nurses described less interaction due to self perception of a lesser understanding and knowledge level. Many concurrently described a desire to increase knowledge and skills around these less common chronic conditions.

I guess with PMR (polymyalgia), I don't have a huge understanding of the disease... it's actually a really difficult disease, I'd like to know more about it. (Fiona, line 386)

Those that did describe interaction with individuals with conditions such as chronic mental illness generally described this within a context of confidence in their knowledge and skills.

It's scary to a lot of people [mental health] not just health professionals, because it's a knowledge deficit. I know I have a bit more knowledge than my colleagues because I have attended studies with [management services organisation] which involves patients we have had through our outpatients department... I'm certainly not frightened of it but it's a subject I can't get enough information on I would happily attend sessions because you can't learn enough about it. (Krista, line 448)

The acquisition of up to date knowledge from recent educational opportunities had positively influenced Krista's confidence in her knowledge.

The role of the individual in information giving and receiving

A few participants portrayed individuals as active participants in the gaining of information regarding diagnosed chronic conditions, while others described individuals as passive recipients of information.

In the context of a person with palliative care needs, Angela described her role in providing information as a means of increasing the individual's knowledge and as a result, their ability to self manage. This was described within the context of the complexity of the system of health care providers that an individual with a chronic health condition may be involved with.

We had a person earlier this year who would only be 48 or 49 and was in the terminal stage of congestive heart failure and we referred him through to the hospice. And he would ring up and say "can I have such and such done?" Like he rang one day and said "my legs are dripping fluid and I don't know what to do, everything is getting wet" and I said "ring the hospice nurse and she'll be there" and then gradually he learnt that he could ring us for things that he needed and if we couldn't meet them, then either he could ring or we could ring (the hospice). (Angela, line 843)

Brenda further described individuals having a desire to know about certain aspects of their chronic condition.

They're curious, they want to know what is happening to their food they're eating and what it's doing to their blood sugars. They come back with questions. (Brenda, line 115)

Fiona described her perception of the individual's need to take responsibility for their actions and learning needs related to their diagnosed chronic condition as an active participant, whilst acknowledging it was the individual that knew the impact of their chronic condition upon themselves.

They obviously know the impact it is having on them on a day to day basis but they need to take responsibility for what they're doing and for learning about it themselves whether it is from us or the internet, support groups etc. (Fiona, line 524)

Further, regarding the view of individuals as active participants in the gaining of information and knowledge, Jenny described finding those that were recently diagnosed as being more motivated than those that had been diagnosed with a chronic condition for a longer period of time.

I find the newly diagnosed are the ones that are more motivated than those that have been diabetic for quite a while that are hard to keep on track. (Jenny, line 68)

Individuals as active participants in their own care, was further supported by information gained through accessing of various sources. However some participants had varying degrees of comfort around these alternative sources of information.

Most people speak to us of other sources [of information] than to the doctors I think. Our doctors are pretty open to what people try. They'd rather know what people are taking, especially medications from the internet. There's the odd one that drives us barmy with the information from the internet, they bring in screeds of paper for the doctors to read and are quite often over the top. (Greta, line 210)

I think there is a lot of information out there, television ads, magazines etc. I think people with encouragement will seek additional information. (Krista, line 180)

The individual client's role as holder of knowledge is described by Ingrid in the context of her work in an A & M facility. This knowledge is described as being utilised to increase her own understanding.

I learn a lot from my patients and I don't hesitate to say to them "I have gaps in my knowledge so you can share with me because this is your area of expertise". I think this comes from working in a Maori community, there must be a sharing of wisdom and knowledge. It's an equal relationship between patient and nurse. They can teach me and I can teach them. (Ingrid, line 229)

This illustrates a mutual information sharing between the individual and the practice nurse with both as active participants, while recognising the knowledge both parties bring to the interaction.

Furthermore, Claire described learning from an individual with a chronic condition while also feeling disconnected from the specialist services.

I can think of this one wonderful man that taught me a lot, bringing his resources from [specialist service], talking about what operations he'd had. It's hard when the patient knows more about their condition than we do and you have to admit that to them. (Claire, line 401)

In this case Claire is acknowledging the information she gained from an individual who had more knowledge than she had, but conversely, difficulty with the concept of having to admit this to the individual perhaps assuming she needed to have the greater level of knowledge.

The individual's family is also described as playing a role in the process of information giving by Krista. This involvement of the wider family (as also

described by Ingrid) was seen as a mechanism to assist the individual to implement the lifestyle changes deemed necessary within the perspective of a diagnosed chronic condition.

We would encourage them to bring in a member of their family with them to be part of it, because they need to know what is going on, not at every visit but certainly the newly diagnosed. For their understanding to help and encourage the patient to make the changes to a better their lifestyle. (Krista, line 169)

The role of the Practice Nurse in accessing information outside of their area of expertise

The majority of the practice nurses described accessing information sources outside of the immediate general practice team in the event that they did not possess the necessary knowledge and expertise. This may have been determined by recognising they could not provide specific information or by when it was apparent that the individual was not taking on board the information conveyed.

Making appropriate referrals as in the case of children [with Type 1 diabetes], getting them to a paediatrician. (Elaine, 173)

If I'm not getting through to them at that point, the 2nd visit, then I immediately refer them through to (specialist service), it just makes more sense. (Angela, line 227)

In situations that appeared more complex, some participants referred the individual to specialist level services, while others described provision of care with the reassurance that the specialist services were available if needed. Alongside this, several participants expressed a reluctance to access these services due to a perception that the specialist services had limited capacity to respond.

They would rather come and see us for their diabetes education, and then I guess if things are in the too hard basket we refer from there. Places like specialist services are very overworked, they have quite long waiting times to get in there, and there are things we can do, knowing that they are there, but we don't need to refer them on at that stage. (Brenda, line 141)

I'm starting out with newly diagnosed diabetics because the specialist service has often quite a delay, or you are referring to a dietician and there's a delay, or they send back your letter and say you need to do this in your practice. So that is quite an issue really, and we do need to get competent in what we're teaching. (Claire, line 220)

In addition, the practice nurse may have directed questions to specialist services when the questions were outside her own knowledge level, acknowledging the generalist nature of her knowledge.

A lot of the diabetes questions, if they are a bit curly, I tend to direct them through to specialist services, but I will do that as well so they're getting back to the person... you can't have expertise in everything when you're a generalist, you have general skills but you don't have expertise or a huge knowledge that the diabetes specialists, or respiratory specialists will... I'm very good at networking with them and using them as a resource. (Brenda, line 447)

In this description Brenda is describing the relationship she has with the specialist nurses acknowledging that when she recognises the question as outside the scope of her knowledge, she referred to this specialist resource of recognised expertise.

The referral of individuals with increasing complexity to specialist services was described within the different types of diabetes. Practice nurses described little specific input regarding Type 1 diabetes, being more likely to utilise the knowledge of specialist services.

They [individual with Type 1 diabetes] tend to be more complicated on sick days and things like that, hospital admissions. It's better to go to the experts and we've got some really good expert nurses on the chronic diseases in this area. (Brenda, line 470)

This acknowledgment of the use of specialist resources because of the increasing complexity of the care, needed was further described by Dianne.

Those that we may not have the specialist skills required, then we would initiate referrals for input into; speciality diabetes services, respiratory, podiatry, we will consult and collaborate with our clinical nurse specialists on individual cases, for their input without initiating a referral... get on the phone and ring them, we may need to put something on paper, their blood glucose, medications etc. and flick it through to them and they will notate their recommendations back to us. (Dianne, line 606)

Here Dianne is describing a collaborative relationship between herself and the specialist nurses, increasing her knowledge, to ultimately meet the individual's needs at the time. By telephoning, this avoided the need for a referral, and contributed to the individual consequently receiving timely and appropriate care.

A lack of confidence in knowledge was further described by Elaine, as a reason for referral to specialist services. This led to disappointment due to the relationships she has already established.

If it's something I don't feel completely confident in handling or answering, or referring them to an appropriate service then I do. I use the

specialist nursing service because she is really great although sometimes I feel it is a shame because I have to offload people I enjoy having a relationship with but therapeutically its better for them. (Elaine, line 318)

Krista furthermore described a positive acknowledgement of personal boundaries.

Yes personally if I am not confident with the condition I would hesitate to offer advice. I would rather refer to somebody who knows what they are talking about. We know there are specialist nurses outside of our practice; diabetes, asthma, arthritis. We would liaise with them over something we cannot deal with, we would refer on to them or a specialist. (Krista, line 359)

Conclusion

Practice nurse participants all described the provision of a range of information to individuals with chronic conditions, within diverse time contexts, and ways of working. The participants repeatedly described the giving of information within discussions regarding most aspects of their care of individuals with chronic conditions, constructing it as a common theme. Approaches to the giving of information ranged from unstructured opportunistic occasions, to structured occasions such as designated clinics, aimed at providing a consistent level of information to the individual.

Rationales for the giving of information appeared to be related to the perception that the practice nurse has a principal role in the education of individuals with chronic conditions to contribute to the ability of the individual to self-manage. The participants' perception of ability to provide the information was further related to perceptions of their knowledge levels, and accordingly, confidence to undertake this teaching

Information given in the context of acute presentations appeared to be primarily centred on technical task-teaching and medication management, and in the planned context appeared to have a degree of consistency of content from visit to visit. This consistency was not necessarily evident between different practitioners in the same practice setting.

The individual's role in this information gaining was at times acknowledged as active participant, with practice nurses supporting this through encouragement of the individual to access additional sources of information, and discussion regarding these. The overall impression was that the practice nurses possessed knowledge that the individual needed to be given.

In recognising the generalist scope of practice of the participants, many described mechanisms of identifying when the situation was outside of their area of expertise, with referral to the GP and specialist services, such as specialist nursing. It was, however, apparent that some confusion existed amongst the participants regarding the referral criteria and services provided by such specialist services, and this required some clarification.

The following chapter will provide a discussion of the dualities that were evident within this research; and these are discussed within the current literature.

Chapter 7

A discussion of the dualities of the contribution of Practice Nurses to the care of individuals with chronic conditions

Introduction

In analysing the data and themes that have emerged from this particular study, a number of dualities were identified. These dualities represent the contribution practice nurses perceive they make to individuals with chronic conditions, within the reality of their practice context. These dualities include:

- Control, monitoring and surveillance and/or client centred care
- A communication system which structures nursing care and/or a computer tool for appropriate transfer of information within and outside the practice
- Perceptions of and real time limitations, and time to build nursing relationships
- Set rules and evidence based practice guidelines and/or client driven care
- Non-compliance and/or client choice and autonomy
- Individuals as passive recipients of information, and/or active participants in self care and client centred education processes
- Medication and lifestyle management and/or nursing relationships and support

This chapter will describe these dualities, and situate them within literature.

Control, monitoring and surveillance and/or client centred care

The majority of practice nurses described structured processes supported by complex recall systems, initiated by the practice to facilitate the ongoing monitoring of individuals with chronic conditions. This often appeared to occur in the absence of acknowledgment of the individual's ability to take responsibility for their own health, with the processes providing a system of nursing and medical support.

We've got everything set up on-line here too with the screening, there's the forms that we have here for the diabetes check but it's all set up on the computer, and before they come in I like to put in as much information as I can. (Brenda, line 188)

A big proportion of recalls are screening, for diabetes or elevated lipids, we can create our own recalls for someone you just want to keep an eye on and set it for a short period of time. Other recalls might be relating to abnormal tests that need follow-up. (Fiona, line 308)

Literature exists in support of the utilisation of computerised systems to improve clinical outcomes for individuals with chronic conditions. In a review of randomised trials evaluating a range of interventions for patients with hypertension, Fahey, Schroeder and Ebrahim (2006) recommend that family practices and community-based clinics should have organised systems of regular follow-up and review of their hypertensive patients to improve blood pressure control. Furthermore, systematic treatment regimes tailored to individual patients and their conditions is described as being "at the heart of better disease management" (Department Of Health [DOH], 2005, p. 26) with recall systems using prompts and reminders described as important to ensure that individuals get the care they need.

The general practice system of prescribing regular visits with rules around how often the individual was seen (and by whom) is illustrated by Helen.

In our practice now as of a few years ago, anyone over 65 has to see the doctor every time they want a prescription. But that means we're not seeing the over 65s as often as we were as a practice nurse. The under 65s we see every alternate scripts, so once every 6 months they have a cardiovascular check with the doctor and the in-between one they see us. (Helen, line 534)

The primary reason for regular visits was described as related to the provision of repeat prescriptions for medications and the GP's legal responsibility. Regular review is described as providing the opportunity for people with long term

conditions and their lead health professional to bring together relevant information, and make sense of what it means for the individual (DOH, 2005). Furthermore, contribution to a reduction in mortality and functional decline of older adults with chronic conditions was associated with multiple follow up visits (Elkan et al., 2001).

Some participants did describe a reduced frequency of monitoring and surveillance once they felt assured that the individual would 'take responsibility' for themselves. This appeared to be linked to gaining familiarity and establishing a relationship with the individual.

Probably if it's the first time I've seen someone, we'll generate that first follow up, but as you work in partnership with that client over a number of times, you know where they are at, you may have negotiated that they would ring and they have, so generally it's a bit of common sense as well as your professional judgement. (Dianne, line 282)

Greta described the general practice team members all working together to ensure that the individual was reminded in a timely manner of recalls that were due or overdue, and frustration if the general practice team members missed an opportunity to undertake this reminding function.

We do have alerts on our patients, one of the things we find with MedTech system is if the girls [receptionists] click on the appointment and type the name in instead of using the F2 key the alerts don't come up. We try to work as a team to catch people and there is nothing more frustrating when someone you have been trying to catch for four months has been in to see the doctor and you've been too busy that you missed them. (Greta, line 70)

The recall can be viewed as a system providing individualised care to the extent that for each identified individual there exists a distinct set of recalls, yet a gap exists in that the system is governed by complex sets of rules negating the opportunity to allow for the individual to be within a system that allows for their distinct needs.

A UK NHS study analysing research from a wide range of health care systems on a number of aspects of chronic care management, found a positive effect on both quality of care and clinical outcomes with disease registries, where information is compiled centrally and utilised to identify and track people with chronic conditions. This positive effect was described when the registry data was used to send reminders to patients about routine check ups and medication reviews (Singh, 2005b). This is further supported by an Australian study in which the

authors concluded that with a continued increase in numbers of persons diagnosed with diabetes placed on computerised registers, there was a correlating increase in most care processes such as regular measures of weight, blood pressure and blood screening, and clinical interventions such as drug treatment (McDermott, Tulip, Schmidt & Sinha, 2003).

In a New Zealand study on the availability and collection of epidemiological diabetes data, the researchers concluded that medical practitioners needed to support the development of their own practice-based registers/recall systems, and contribute to the development of district-based diabetes registers where these have a central focus on improving diabetes care (Wilson, Mansoor & Simmons, 1999). This is demonstrated by the participants' description of the FAC computerised data collection tool, with the ability to communicate information to a central point, The Diabetes Trust.

In contrast to the described control monitoring and surveillance, client centred care may be demonstrated by individual choice regarding general practice recommendations of regular screening tests and visits. This requires practice nurses to work in partnership with the individual, and knowing patients and their particular circumstances is critical to allow nurses to work in ways that will enhance genuine partnerships according to Russell, Daly, Hughes and Hoog (2003). These authors suggest that 'knowing patients' enables more dynamic relationships between patients and nurses, in which patients are regarded as experts about their own lives, and nurses must acknowledge the importance of patient's self knowledge. These authors suggest that this will require a paradigm shift, transferring a degree of authority and power to patients, and nurses need to recognise the patient's expertise to make rational decisions about the way treatment recommendations impact on their own lives (Russell et al.).

A communication system which structures nursing care and/or a computer tool for appropriate transfer of information within and outside the practice

The use of a computerised client record and practice management system was described by all participants. This was described as visibly providing a function of structuring, reminding, auditing and monitoring nursing care, while controlling

interactions with individuals. Additionally, the computerised system was relied upon to provide means for a large amount of communication between the practice nurse and other team members, primarily the GP. However this system was dependent on a number of variables, including the amount, type, and timing of recording of clinical information in the computerised notes, the practice nurse's capacity to review the information recorded in the computerised template, and the manner in which this was reviewed and utilised.

We might not get the file with them, just the person and we'll only have limited information from the computer notes. We don't have disease coding, so we don't always know what their disease is. (Claire, line 396)

In this case Claire is describing an absence of verbal communication following GP referral to the practice nurse, with reliance upon the computerised record. As a result, where both paper and computerised notes exist, delayed recording in the computerised notes by the referring GP directly limited the information the practice nurse had access to regarding the individual she was about to provide nursing care to.

Helen describes her role in relation to individual test results that are sent via the computerised system by the GP for actioning.

When the lab results come in are you seeing them as a practice nurse?

That's a turn around from the mail. The GPs actually see them first because they come in electronically now. Then they flick them across to us if they need to be actioned.

So they do the first screening and you see more the abnormal ones?

We get the red ones, the ones that need action.

And you would then arrange for follow-up?

Yes, there's usually a coded sort of message on what sort of follow-up is required. A lot of them, we get around with a quick letter. (Helen, line 687)

This computerised method of communication is dependent upon the practice nurse and GP having a shared language around interpretation of the 'coded messages'. It may be able to provide an effective and efficient method of communicating complex material such as laboratory results requiring some level of follow up, but it is questionable as to whether it can be relied upon as a

principal method of communication as described by many of the practice nurse participants.

Dianne describes her confidence to verbally communicate to the GP any queries or concerns she has following a computerised 'conversation' around the processing of cholesterol results.

We enter their cholesterol level onto the computer with a notation of the risk factor, what the recommendations are. Which could mean that they need specific lifestyle changes or general changes, or intensive dietary and lifestyle changes. You may need to look at commencement of statins, or if they are already on them but not at the recommended cholesterol level then we would make a suggestion of increasing statins. If they're on the top level we would suggest to the GP that we incorporate another medication, a lowering cholesterol medication as well. The GP may have put them on a higher statin which they have reacted to, so you look at their allergies etc. All this will be noted on their file and sent to the GP. They will reply with changes and sometimes they'll rationalise these with us. I think we have the relationship with each other that if we don't agree we can ask for their rationalisation.

So if you've made a risk assessment and recommend a change, but the GP doesn't agree, you feel confident enough to question that decision?

Yes, often I'll send a message back, as to why? Sometimes there may be a condition I'm unaware of, the GP may have seen that person within the last week or so and have information that I don't have. (Dianne, line 449).

The computer could be viewed as a tool for recording and communicating certain information regarding an individual, but not intended as a substitute for personal communication between team members.

Regarding the use of computerised systems for clinical notes, a summary of systematic reviews by Brouwer, Bindels and Van Weert's (2006) found data quality of medical records assessed in terms of completeness and correctness, varied greatly. They concluded that data quality improvement studies in general practice are few, and very often not up to the standard of intervention study methodology. Most attempted interventions are described insufficiently and aimed at improving adherence to "norms of good record keeping" (p.535). This results in a lack of empirical knowledge as to how improvement can be facilitated in the general practice setting (Brouwer et al.).

Recent literature from the UK describes a national approach to standardisation of electronic medical records, through a summary care record tool containing all

significant aspects of a person's care, such as major diagnoses and problems, procedures, current and regular prescriptions, allergies, adverse reactions, drug interactions, recent investigation results, hospital discharge summaries, outpatient summaries, and summaries from pathways of care (Chantler, Clarke & Granger, 2006). The aim is for the summary care record to be derived from the detailed patient record systems of all organisations providing care to the individual, as an aspect of the NHS programme to make more effective use of information technology. Currently more than 90% of general practices in England are computerised, with patients' medical records being held electronically in at least a third (Chantler et al.). Within my study of practice nurses' perceptions there was limited evidence of utilisation of the computerised system to transfer information outside of the practice.

This lack of evidence of utilisation of computerised systems of data transfer is supported by the findings of a New Zealand study in 2005, authored by the National Health Committee as a discussion document to gain advice to the Ministry of Health, on how to better support people with chronic conditions in New Zealand (NHC, 2005). Within this, health care professional participants described funding arrangements for health care of individuals with chronic conditions that did not recognise the increased cost associated with providing services to people with higher need and multiple chronic conditions. It was also noted that funding for primary health care had not kept pace with the growing information technology needs and growth in patient numbers. It was suggested that a separate category should be created for people with 'complex and chronic conditions', with specific funding and policy initiatives designed for this group. Further highlighted was a need for better sharing of information using technology with an example of having summary clinical information on patients accessible on a central server or a website with password access (NHC). This is comparable to the NHS approach to standardisation of electronic medical records.

Perceptions of and real time limitations, and time to build nursing relationships

Many participants described establishing a positive relationship with the individual with a chronic condition, which they perceived contributed to the ongoing care of the individual.

But I really feel that building a relationship with that person, even if it is only an isolated incident, helps me in that form of education. I always try to find some common ground with them and if I can build that relationship with them initially they are more receptive. (Ingrid, line 215).

The development of this relationship within the organisation of nursing care around such roles such as 'case management' was described as provided in an attempt to meet individuals' needs.

I also talk to them about case management and if they want to keep seeing the same nurse, because we all work part-time. I understand that people form relationships and we try to keep those relationships to where people feel they are working. (Elaine, line 64)

We do like for that person [with a diagnosed chronic condition] to be case-managed by one individual practice nurse, so that they can develop that relationship. It can be quite hard for them if they have a different nurse each visit, so we do try and just have the one nurse. (Dianne, line 71)

Case management by practice nurses may consist of assessment and planning of care, then negotiation with the GP regarding referral outside of the practice (Evans, Drennan & Roberts, 2005). This is comparable to an earlier participant description of the necessity to negotiate with the GP regarding appropriate referral, and coordination of care. However there is conflicting evidence regarding the benefits of case management, described as perhaps not always being beneficial for people with long term conditions (Singh, 2005b).

Most practice nurses clearly described work schedules that in many instances limited the time with the individual client. This included the limited capacity to provide appointments longer than five minutes due to workloads, and the visits of an unplanned nature, when care was delegated from the GP. Nevertheless, there was description of innovative attempts to fit as much as could be into a limited time context while carrying out initial assessments of all individuals presenting to an Accident & Medical centre. This contact included establishing a relationship with the individual and family/whanau, assessing immediate needs, past history, knowledge level and immediate concerns. Nursing input was also often provided after the individual had seen the GP, ensuring that the individual was prepared to return home able to continue to self-manage their chronic condition. This represented the practice nurse acknowledgement of the need to establish relationships with the individual, within a limited time context.

The literature supports the need for time dedicated to the development of nursing relationships, to enhance outcomes for individuals with chronic conditions. Russell et al. (2003) argue that knowing patients results in nurses becoming better positioned to interact in ways that are meaningful to the individuals, enabling them to bring information about patient's lives into the process of health care decision-making. This they suggest, creates an advocacy role for nurses where they need to listen to patients, and accept them as experts in their own lives and health choices.

This is further supported by Pooley, Gerrard, Hollis, Morton and Astbury (2001) who examined issues perceived as central to the management of diabetes. They concluded that importance must be placed on providing an environment in which patients can raise concerns, and health professionals can spend time "learning about the patient's view of their conditions" (Pooley et al., p. 322). This was seen as being influenced by health professionals' ability to make a patient feel comfortable, and commitment to an approach which is patient centred. The role of listening was also highlighted as critical to enhancement of the patient's ability to self manage. Participants in the study by Pooley et al. described that although patients knew how their diabetes affected them, health professionals paid too little attention to these views. The importance of two-way communication was further emphasised as integral, and health professionals acknowledged the importance of "viewing the world through the patient's eyes even if it did not coincide with their own perception" (Pooley et al., p. 323). This concept of adequate time can be viewed as a core component to the establishment and maintenance of effective relationships.

A potential means of addressing time constraints was demonstrated by the organisation of care of the individual with certain identified conditions into designated clinics with longer appointment times. Time allocated to the FAC was another example of the allocation of additional time for a visit.

We do free annual diabetes checks, the client would come in and spend half an hour with the nurse. (Dianne, line 61)

This increased allocation of time around particular chronic conditions is related to a national approach to diabetes, as a priority area to be addressed by the general practice team. This check is also at no cost to the individual, being funded by the government, which may also influence the business owner's decision around the

provision of increased nursing time. It could be argued that this is at the expense of nursing care provided to individuals with other chronic conditions such as the most prevalent conditions in New Zealand of cardiovascular disease and respiratory disease.

To illustrate this, Dianne describes the impact of respiratory disease being given less priority by the practice.

....it's the national guidelines recommendation that they [person with asthma] should have a plan. However when people come into the surgery, and it's episodic or emergency, they see the GP, interventions are done and they go. They don't have education with the Practice nurse always and you can't have an asthma plan without that education. It's all very well giving them a plan but if there's no educator to negotiate with them, if they can't read, what's the point, you have to negotiate with the client, "what are your objectives, your symptoms?" rather than using numbers and I do see that as the nurse's role. But it doesn't seem to be a priority from the practice, not from a nursing perspective, I think more from the GP perspective. (Dianne, line 349)

Newman, Steed and Mulligan (2004) in research examining the background, content and efficacy of programmes developed for patients to better manage chronic conditions, concluded that time allocated for Self Management Interventions (SMIs) for respiratory conditions, namely asthma, was markedly less than that allocated to individuals with Type 2 diabetes. This was related to different objectives of care. For asthma, these objectives centred on prevention of acute exacerbations, monitoring of symptoms and consequent adjustment of medications, improving adherence to medication. In contrast, for diabetes, the interventions tended to be more diverse with a focus on lifestyle issues and the management of stress.

A paper released by a group of researchers describing the role, functions and services provided by practice nurses in HealthWEST PHO (a PHO in Auckland) supported the earlier New Zealand study by Lightfoot et al., concluding that the majority of nurses were focussed primarily on traditional nursing tasks with chronic disease management of respiratory and heart disease being more GP led, whilst the management of patients with hypertension, and diabetes more likely to fall within the practice nurse domain (Horsburgh et al., 2005). These findings are comparable to the findings of this research when considering the types of chronic conditions the practice nurses described being involved in, with possible differing objectives of care shaping their work.

Some participants did describe autonomy over allocation of time for practice nurse appointments, altering this in response to their perception of the amount of time required for each particular visit.

The doctors have a standard appointment time of 15 minutes, and we've made that, but the receptionists know that if we're doing a vitamin B12 for instance that that doesn't take 15 minutes, the flu vaccine again doesn't take 15 minutes to give, so we can double up, and they can do that, and often if we're getting people back for blood pressure monitoring, and originally we've talked to them, we've spent a longer time with them, we're doing some monitoring that might not take as long, so they have licence and we can see where we can squeeze some things in as well, but on the whole it's a 15 minute appointment. Which is really nice, especially as we have quite a large elderly population, you can spend some time with them and they don't feel rushed.

So if you needed a longer time you would schedule that yourself?

We would schedule that ourselves. I know for instance, I think I've got three new diabetics coming in and so I've got half hour appointments to spend with them, so we can alter that, it's entirely up to us to what we do. (Brenda, line 80)

Conversely some participants described rules within their practice setting, and particular responses to occasions where the visit went over the allocated time.

Yes, there are very strict guidelines of what should be covered at each visit and should they go over the time, the patient is then encouraged to reschedule for the next week or two. (Krista, line 95)

Congruent with the described time constraints, Pooley et al. (2001) revealed time as one of the significant factors critical to self-management. This included sufficient time during consultations to ask questions, give information, and agree on a course of action in accordance with the patient's desires. The lack of time to effectively deal with patient concerns, and the belief of patients that it was unrealistic to prolong a consultation by asking too many questions, were repeatedly cited as issues that both restricted the services health professionals felt they could provide, and irritated patients who wanted more information. Sufficient time for communication was seen as critical to effective consultations, and many participants described the constant conflict between the service they wanted to provide and the care that was possible within time constraints. Of the health care professionals participating in the research, practice nurses articulated their views most strongly (Pooley et al.).

Furthermore, Frich (2003) concluded in an integrative literature review of the care of individuals with chronic conditions, that increased time spent with individuals with diabetes was related to positive clinical and quality of life outcomes.

When considering how the practice nurse participants have addressed time constraints through the organising of care around specific diagnoses, this is comparable to the UK NHS attempts to organise services for people with long term conditions. The NHS is advocating the use of the 'Kaiser Permanente triangle', with a three tiered approach to stratification of patients' needs, to identify and match specific care needs (see Figure 1). At the top of the triangle are those individuals identified as requiring case management, the middle portion requiring disease specific care management, and at the broader base, the individuals with chronic conditions requiring supported self care.

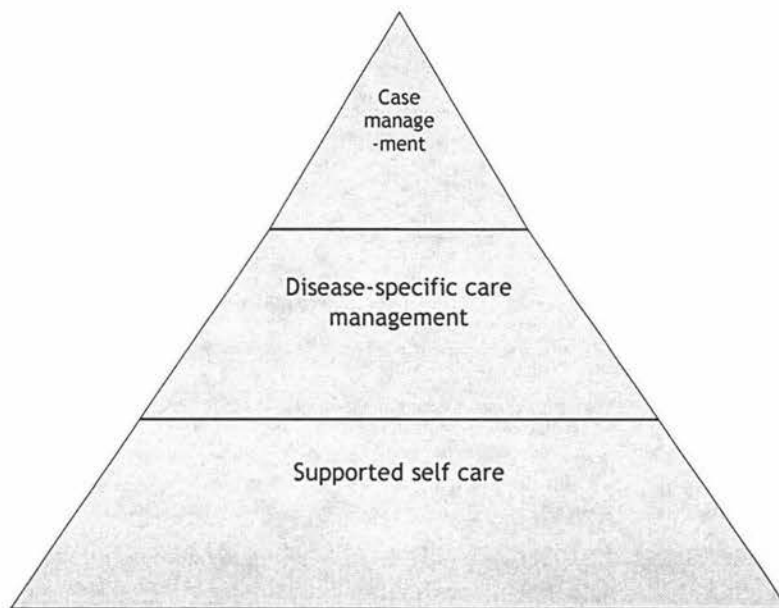


Figure 1: NHS model based on Kaiser Permanente triangle
(DOH, 2005, p.10)

In considering the application of this model to the work of the practice nurses, it could be concluded that the individuals with chronic conditions to whom they are providing care, may be within any of the three areas of the triangle, however, the care they describe providing appears to be consistent with the supported self care area. The aim of the self supported care is “collaboratively helping individuals and their carers to develop the knowledge, skills and confidence to care for

themselves and their condition effectively” (DOH, 2005. p.10). However, supporting self care is described as more than giving patients information about their condition, and also about acknowledging the patient’s central role in managing their own care and empowering them and their family to manage their condition as effectively as possible. Some clients, although not all, will also need different levels of care, for example case management.

Set rules and evidence based practice guidelines and/or client driven care

Practice recommendations (or rules) such as those concerning the individual gaining a repeat medication prescription for their diagnosed chronic condition, and regular visits to the general practice, typically structured care the practice nurse participants provided to individuals with chronic conditions. These recommendations provided the general practice with a mechanism of ongoing monitoring of the individuals.

In addition, some participants described the care of individuals with chronic conditions being informed by guidelines, including chronic conditions such as diabetes, cardiovascular and respiratory disease. While participants described that national guidelines may be present in the practice, they were not necessarily used as a basis for determining the care the individual received, due to reasons such as the reduced priority the particular condition may have had in the practice. This is a significant finding that challenges both the educational preparation, and the scope of the practice nurse as a Registered Nurse. Additionally, the guidelines may be present in the practice setting, but not necessarily utilised by any or all of the general practice team members.

Because the practice nurses assess the cardio-vascular risk of all the clients that have lipid profiles done in the practice, we use the guidelines. We also use the asthma/COPD guidelines, however, there are barriers within the working environment to actually apply them. (Dianne, line 424).

For the priority area of diabetes, Dianne described attempts to individualise care within guidelines.

Well, with Type 2 diabetes management you have the national guidelines and so it’s a matter of are we meeting what has been researched and is evidenced based? Is our client meeting that? It sounds terrible because you are putting everyone in boxes, and just because you have that guideline it

doesn't mean it will fit that person. Sometimes you have to be flexible, because an HBA1C for an eighty six year old lady may be a bit higher than someone in their twenties, so even though there's a guideline to guide it, it's not yes, no, yes, no. But we have to be able to rationalise why they're not staying within the guidelines. So there's some with diabetes with higher HBA1C's and I would be collaborating with the GP as to what dimensions we can use. As well as with the client to be able to get that HBA1C down to an acceptable level, to reduce the long term complications. (Dianne, line 409)

Dianne does however acknowledge the need to provide a rationale for when the outcomes of care are not within a particular guideline, hence attempting to assure that individualised care is provided while being evidence-based. This care was determined in partnership with both the individual and the GP in order to maximise potential outcomes.

According to the UK DOH (2005) the value of agreed clinical standards and protocols to improve the care of patients with long term conditions has been long recognised. These are seen as an integral component of pro-active disease management, potentially making a difference to patients by producing better health outcomes, slowing disease progression, reducing disability and ensuring improved management of sudden deteriorations often associated with long term conditions. This results in improved quality of life for patients and reduced need for hospital admissions.

In New Zealand the Guidelines Group (NZGG) provides a comprehensive resource to policy makers, health professionals and consumers regarding a range of evidence based resources and guidelines. The mission of the NZGG is to set the standard for an evidence-based approach by:

- sharing information and knowledge about evidence-based information and effective practice initiatives;
- establishing strong collaborative networks in the process of guideline development and implementation;
- training clinicians, providers, consumers and researchers to find and assess evidence and adopt an evidence-based approach;
- disseminating information about and fostering the development of expertise in guideline development and implementation;

- providing trusted, impartial, expert assessment of New Zealand and international best practice guidelines;
- facilitating the development of Centres to support evidence-based activities (NZGG, 2006).

The values and work of the NZGG are closely aligned with the New Zealand health sector's approach to improving quality in the health and disability sectors. The presence of such guidelines does provide general practice and practice nurses and clients with an accessible source of evidence-based guidelines.

Non-compliance and/or client choice and autonomy

When considering client centred and driven care the participants described varying responses to the individual's choice to not follow practice recommendations. The negative response of the individual to the general practice prescription of regular care for those with diagnosed chronic conditions was acknowledged by some participants as acceptable. This can be interpreted as acknowledgment of the individual's right to self determination of their level of interaction with the health care system generally, and the general practice in particular, regarding their diagnosed chronic condition. Helen describes this regarding an individual's visit for repeat medication prescriptions.

Does it happen that they choose not to deal with the practice nurse for that check?

Yes, and often it's that the person is in a bad space at that time and I always give the prescription but advise the receptionist to say that they must come in within the next week and if they don't, I note on their file that they must be seen by next script. (Helen, line 625)

Furthermore, Krista uses an 'encouraging' approach, backed up by the computerised reminder system, but is careful to not continually advise them of the practice requirement to be seen.

We send the initial invite, we do follow-up, we have a system on the computer that will indicate if the patient hasn't been in. You can then invite again with either a letter or a phone call. It's encouraging them. A phone call can sometimes make or break it, it may be that someone is just not interested and we certainly are not going to pester them. (Krista, line 206)

However, Greta views an individual's choice to not follow practice recommendations as a purposeful act by the individual, possibly to avoid the prescribed visit to the GP.

Some deliberately leave it too late to get their medication because they know the doctors are busy and won't be able to see them. We give them a script for a month and get them back in. (Greta, line 274)

When considering individual choice to not follow the general practice recommendations or requests, Snelgrove (2005) takes a negative perspective and describes this as non-compliance, and as patient failure to follow the advice of health professionals. This is seen as costly for patients in terms of persistence of disease or worsening health, and damaging to the relationship between health professional and patient, leading to wider costs. However Snelgrove does acknowledge the terminology 'compliance' as problematic often being used interchangeably with 'adherence' or 'concordance', leading to a lack of clarity, implying a need for unquestioning obedience with no opportunity for choice.

The practice nurse participants' description of a role in facilitating individual agreement to practice recommendations or 'compliance' is supported by various authors. Kyngas (2000), while identifying factors that predicted compliance with health regimes for adolescents with asthma, concluded that the most powerful predictor of compliance was support from nurses. Several studies reviewed by this author indicated that compliance can be improved by good relationships between health care staff and clients, with these emphasising the importance of enabling individuals to actively participate in planning their care together with health care staff. The establishment of relationships as central to the ongoing care of individuals with chronic conditions has been described by the participants in this study, as something they strive to achieve through such concepts as continuity of care.

When considering this concept of continuity of care, both patients and health professionals in the study by Pooley et al. (2001) expressed concerns regarding the lack of this. Patients expressed a desire to see the same person each time they attended, and health professionals complained about problems of communication and coordination between different providers of diabetes care. From the patients'

perspective, continuity can avoid the unnecessary repeat 'story telling' they needed to do each time they saw someone new. This lack of continuity can be seen as further complicating the time constraints previously described, when the health care professional is not 'up to speed' with knowledge about the individual.

DiMatteo (1994) refers to research signifying that the determinants of adherence tell us that patients typically follow only the recommendations they really believe in, and those they actually have the ability to carry out. Also acknowledged were the practical difficulties patients face such as not being able to take time off work for appointments. DiMatteo concludes that patient involvement in decision making that affects their health and future is essential if they are to make the commitments necessary. This has significance when considering the role the practice nurse fulfils in response to the individual choice to not follow the general practice recommendations regarding regular visits.

Russell et al. (2003) indicated that promotion of patient compliance is an integral part of high quality nursing care and nursing interventions aimed at improving patient's non-compliance derive from specific assumptions about what is causing this. The assumption is that if health care advice is based on scientific evidence and the treatment will benefit the patient, and it is rational to assume that patients will follow the advice. These authors described the lack of acknowledgement of the range of factors that may influence decision-making of patients. It was concluded that there was a need for a paradigm shift, transferring a degree of autonomy and power to patients, with nurses recognising patients' expertise to make rational decisions about the way treatment recommendations impact on their lives. It was also suggested that "removing notions of compliance and non-compliance will allow nurses to take a leadership role in bringing knowledge of patients' lives into the health care decision making process" (Russell et al., p. 282).

Individuals as passive recipients of information and/or active participants in self care, and client centred education processes

The giving of information as described in chapter six, highlights the role participants undertake in the giving of information. This was particularly evident in the initial post diagnosis phase of a chronic condition. Some participants did describe making an assessment of the individual's need for, and ability to retain information at the time, although this was the exception rather than the rule.

I suppose it comes naturally really, sometimes information overload is obvious because they've just come from the doctor, or they're only focusing on their blood pressure and they know it has to be better. They haven't got the whole picture, so it's assessing them, how much information they can cope with at the time. (Claire, line 143)

Additionally, some participants did also describe individuals taking an active role in information seeking through alternative sources such as the internet. However this was met with various responses. Krista describes an encouraging approach to individuals accessing additional information regarding their chronic condition.

There is a lot of information out there; television ads, magazines etc. I think people, with encouragement, will seek additional information. There is a lot of recognition of chronic diseases and promotion of education and prevention of complications. (Krista, line 170)

In on-going visits some practice nurses described reassessment of knowledge the individual had gained from previous visits. Some appeared to utilise this reassessment to inform subsequent planning or delivery of care at on-going visits, alongside describing appreciation of the need to be aware of the individual's needs at the time.

We ask what they understand of what's been said etc, do they have any questions, have they looked through the resource folder we gave them? (Krista, line 189)

Participants described providing a range of types of information to individuals both at diagnosis, and in an ongoing capacity. All described providing additional written resources. Regarding the use of additional resources, the NHC (2005) described individuals with chronic conditions consistently not getting the health information they needed, and that information was not always in an appropriate form. Many participants described pamphlets as not always the best way to inform them. This was further supported by a review of local initiatives to transform chronic care undertaken by a group of Primary Care Trusts in the UK, which concluded that written information may improve knowledge, but when used alone

will not usually affect people's behaviours, quality of life or clinical outcomes (DOH, 2005).

The role of the nurse as educator is widely recognised as an integral component of nursing, particularly within the practice nurse role in New Zealand (New Zealand COPN NZNO, 2003b). Furthermore it is a component of the role of the primary health care nurse, in contributing to the implementation of the PHC Strategy (MOH, 2003b). Therefore, practice nurses as a group of PHC nurses, are viewed as a vehicle for providing health education to individuals.

Russell et al. (2003) postulate that to enable nurses to present health information in a way that is relevant and therefore useful to the patient they must know their patients, this being critical to allow nurses to work in ways that enhance genuine partnerships. The ability of the nurse to bring information about the patients' lives into the process of health care decision making needs to be supported by nurses' acknowledgement of the importance of patients' self knowledge. This is based on relationships where patients' expertise is given credibility.

This view of patient expertise is supported by Newman et al. (2004) who concluded SMI developed for patients to better self manage chronic illnesses accompanied a trend away from a system where health care professionals were seen as experts and patients as passive recipients of care. More collaborative care, where expertise was shared between patient and professional, was advocated. Early influences in patient self management were described as educational approaches, principally providing individual patients with information in a traditional didactic format, with the expectation that greater knowledge would lead to an appropriate behaviour change. This use of individual interventions was justified as modifiable to the needs of the individual, and easier to integrate into clinical practice. These authors concluded that knowledge alone is not sufficient for behaviour change, and a key feature of SMIs was to increase patients' involvement and control of their treatment and its effect on their lives (Newman et al.).

On a positive note within this study of practice nurses' perceptions of their contribution, descriptions were provided of practice nurses working in partnership with individuals and their families, sharing knowledge and expertise, in

acknowledgment of the shared experience of knowledge acquisition. Whilst some participants demonstrated the use of traditional didactic information giving, some did describe individuals as active participants in acquiring knowledge through assessing current knowledge, promotion of self initiated sourcing of knowledge, and being cognisant of information overload and the potential need to limit information at any given visit.

Medication and lifestyle management and/or nursing relationships and support

Participants described undertaking a distinct management function focussed on the complex provision of medication prescriptions to the individual with diagnosed chronic conditions. This appeared to result in the practice nurse applying a medication focussed approach or lens to many of the interactions with individuals with chronic conditions shaping the practice nurses to work in a particular way, which arguably is not in keeping with their education, and nursing focus on the whole person.

For the HBA1Cs, it's simple. If they're above a certain level then they get a 3-month recall, if they are stable and they are well within a good and acceptable range they will get a 6-month recall. For those that are progressively going up and up or even just consistently sitting at a high level, a bit more goes into that, you need to go into their notes, when were they in, did we change meds. A bit of investigation into what's been done recently and if they have been having regular monitoring, make the recommendation that they come in to see the practice nurse or the doctor for a medication review. (Elaine, line 250)

This focus on the role of medication in the care of individuals with chronic conditions apparently provides a tangible reason to request the individual to attend the practice for a further review. There existed, at times, an absence of nursing assessment of wider factors that may have influenced a particular presentation of the individual, beyond the role of provision of regular medication.

A 'lifestyle management' focus was also evident from the participant descriptions. Areas such as diet and exercise, were examples of key factors reviewed during visits associated with chronic conditions, appearing to once again drive the practice nurse to conduct the visits in a particular way, perhaps not always mindful of the individual's actual needs at the time.

We've gone into some lifestyle things about weight, exercise, alcohol, employment as well, if they've got jobs where hearing could be implicated

as well. We are trying to start this ourselves and I'm sure there'll be other ones out there but it's a starting point for us. (Brenda, line 362)

I always explain that lipids don't just cover heart disease, there's all the other factors of your weight, exercise, diet but until you've actually had that conversation with someone... that's where I think that we need to be taking more opportunities to do that, and maybe in the past we haven't because it's been user pay. We have offered nurse consultations for dietary advice and people are very reluctant to take it up for a consultation fee. It's quite time consuming. (Claire, line 113)

When considering the role of the practice nurse in 'lifestyle advice', Moore and Adamson (2002) found that among a sample of health practitioners in the UK, that although 99 per cent thought nutrition was important, 76 per cent thought they had insufficient time to advise patients adequately. This is comparable to the time constraints depicted by the majority of the participants in this research.

Step toe (2003) found behavioural counselling to be more effective than nutrition counselling, and McKeivith (2005) concluded there was evidence that primary care interventions can offer a beneficial influence on food choice, and behavioural counselling and tailored nutrition messages were the more successful methods for bringing about positive food choices in primary care interventions. Practice nurse participants in this research did not provide any description of elements of behavioural counselling, principally describing dietary and nutrition advice.

In contrast, when considering the nurse's role in support of the individual, the participants described a role of 'listener' and giver of information, able to spend time with the individual answering questions, and generally being available to them. This further supported the practice nurses' perceptions that they spent time establishing and maintaining relationships, which were viewed as beneficial to the care the individual received.

Your ability to spend time, to listen, to give information, to answer questions. It's that whole communication thing. It's being available which practice nurses generally are, even if it's not immediately. (Helen, line 974)

This perception can be further influenced by the practice nurse's awareness of what the individual actually viewed as useful or helpful to ongoing self-management of their chronic condition.

Baum (2005) provides a critical perspective on the role of health education as an aspect of health promotion activities undertaken by health professionals working in general practice. In consideration of individuals living with chronic conditions and the role of the practice nurse in giving information, Baum refers to the various models of behaviour change, conceptualising health behaviour as based on reason and active choice. This supports the suggestion made earlier by DiMatteo (1994) that individuals have reasons for health behaviour, such as a belief in recommendations, and perceived ability to carry these out.

Baum (2005) also proposes that these behaviour change models are based on the false assumption that once people are provided with sufficient information, and support for their decision, then they will change their behaviour. This also assumes that people will actively choose their behaviours according to those they believe are good for their health, and that health is a central consideration in peoples' decision making. She describes evidence that suggests screening, followed by educational intervention, has little impact on risk factors. More specifically, screening for behavioural risk factors for cardiovascular disease in terms of dietary assessment and lifestyle appraisal aimed at bringing about behaviour change, have been more prevalent in recent years, but with limited success (Baum).

Medical interventions are also described by Baum (2005) as being most promising as part of a population approach based on a socio-environmental view of health, although within general practice, health promotion is usually seen as synonymous with individual behaviour change. She does suggest that medical and behavioural approaches do have a place in the portfolio of health promotion approaches, when incorporated within a broader socio-environmental approach.

Conclusion

The dualities described demonstrate the complexity of the practice nurses' role as a member of the general practice team. It was evident, at times, that both elements of the described dualities existed, although it was also evident that the participants were working within complex systems whereby it was difficult to achieve the balance desired as recommended in the literature.

A significant level of control and monitoring was undertaken by the practice nurses regarding the care of the individual with chronic conditions. This was supported by intricate computerised systems which appeared to communicate, structure, audit and remind the general practice team members, and diagnosed individuals, in terms of regular attendance, and ongoing surveillance. The use of computerised systems to improve outcomes of care for individuals with chronic conditions, is supported by international literature. The challenge exists to maintain a balance between a supportive system, and care that is client centred.

The practice recommendations that became apparent, were at times supported by evidence-based guidelines. However, variation did exist in the presence and utilisation of such guidelines, apparently being principally determined by the employing GP, although some participants did describe attempts to contribute to these decisions. Both national and international literature recommends the use of evidence-based protocols to support the management of individuals with chronic conditions alongside the ability to individualise care.

The repeatedly described time constraints provided challenges to the practice nurses' provision of individualised care to the individual. Sufficient time is a critical factor identified by the literature as necessary in the provision of acceptable care, from both individuals' and health professionals' perspectives. This focus on individualised care was further challenged by the view the practice nurse fulfils a key role in giving information to the individual, at times minimising the individual's perspective of what may be important to them at the particular time. According to the literature, the nursing role in information giving has historically been based on false assumptions that information given equals behaviour change. Critical literature challenges this assumption, alluding to the need for a broader approach to the role of health education focussing on the wider variables that affect individual health behaviour and choices.

Acknowledgement of the individual's right to choose their level of acceptance of general practice recommendations varied within this study. Practice nurses' capacity to discuss and challenge such determinants of care within their setting, was apparent in some cases, in efforts to individualise care. The literature on compliance, or adherence, is conflicting, with compelling research supporting the need for nurses to work in partnership with individual's, acknowledging the range of factors which influence individual choice to follow recommendations.

Evidence of this partnership was demonstrated by descriptions of establishing and maintaining relationships between the practice nurse and individuals, viewed as positively enhancing the ongoing care relationships with the general practice team. Various literature supports the positive effect of the nursing role in establishing and maintaining relationships through a partnership approach. Participant descriptions of nursing support provided through availability, responsiveness to acute and ongoing needs, the desire for continuity of care, and overseeing of the individual's journey through the general practice visit, all provided a sense of a true *nursing focus* on the needs of the individual within an holistic approach.

The following and final chapter will provide a study summary, and conclusion of the findings of this research, making recommendations both for practice, and further research.

Chapter 8

Study Summary and Conclusions

Introduction

Qualitative research is described as useful for looking at human experience, allowing the researcher a view of a problem or issue from an emic perspective. The perspective of the participant and descriptive research enables health care professionals to describe what exists in practice, to classify information for use in health care disciplines, or to discover new information, providing a comprehensive summary of events in everyday terms (Field & Morse, 1985; Minichiello, Sullivan, Greenwood & Axford, 1999; Sandelowski, 2000). This study has used an exploratory descriptive approach to examine practice nurses' perceptions of their contribution to the care of individuals with chronic conditions. The purpose of this chapter is to provide a discussion of these findings. Also included are implications for practice and recommendations for further research.

Discussion of themes and summary

Three themes and a number of sub-themes emerged from the data. It was apparent that all participants were engaged in the three aspects of contribution, with these often occurring concurrently. The systems that the participants describe working within pose certain challenges to the fulfilment of the role of Registered Nurse. These will be summarised within the theme discussion.

Theme one: Preparation of the individual for an appointment at the general practice

The preparation of the individual for an appointment at the general practice included significant systems that provide monitoring of individuals with chronic conditions. Tasks associated with recall, monitoring, telephone contact, and regular medication facilitation provided the foundation for a considerable array of complex processes, undertaken predominantly by the practice nurse. The principal

reason for such systems was described as the assessment of the need for the individual to attend the general practice. This preparation served to provide a level of care both before visits, and as an ongoing function between regular visits. The role of the practice nurse in ensuring individual 'compliance' with general practice recommendations was also a compelling feature.

The use of computerised systems for clinical records were described as central to the organisation, ordering and communication of information regarding the individual with a chronic condition within the general practice settings. The use of this, however, varied between practice settings, dependent on all providers within the practice utilising this to its full potential, at times apparently negating the function it was expected to fulfil. There was an absence in the majority of participant settings, of utilisation of these systems to communicate information outside of the general practice.

Theme two: Care provided by the Practice Nurse at the general practice

The practice nurses described a significant role in the care of the individual with chronic conditions through visits to the general practice, with the practice nurse. This care centred primarily on the identified priority areas of diabetes, cardiovascular and respiratory diseases, with lesser description of care of individuals with other diagnosed chronic conditions. The practice settings determined the priority assigned to care provided by the practice nurse to individuals with chronic conditions. The care provided by the practice nurse participants was at times independent, or more often as a precursor to the individual seeing the GP, posing questions around the autonomous role of the practice nurse as a Registered Nurse within the general practice setting.

Many participants described recommendations within their settings regarding the frequency of expected follow up of individuals with chronic conditions. These prescribed recommendations, and nature of the care provided by the practice nurse varied according to the particular chronic condition, and how the practice nurses' work was organised. Limited rationales were given for these recommendations, besides GP accountability for ongoing surveillance commonly associated with prescribing of medications.

All participants described their work organised through nurse appointment books, and additionally a number of participants described the organisation of care into designated clinics such as diabetes and cardiovascular disease clinics. These provided a consistent approach to the care provided to the individual both at diagnosis, and in an ongoing capacity. The principal rationale for such clinics was the allocation of an increased amount of time to provide nursing care to these individuals, with all participants describing time constraints upon their day to day work.

The significance of establishment and maintenance of nursing relationships was a common feature the participants described striving to achieve. This existed within constraints such as time limitations, and practice determined recommendations around the role of the practice nurse. Through the communicated availability of the practice nurse to the individual, allocation of specific time to regular visits and clinics, promotion of continuity of care between the individual and a particular practice nurse, and organisation of care around such concepts as case management, these all contributed to the formation of relationships described by the participants as critical to the ongoing self-management of the individual.

The use of guidelines to support the provision of evidence-based care was highlighted by some participants as problematic, due to the need for the nurse to fulfil the role as navigator of complex rules that frequently differed between the GPs within the practices. This posed further challenges for the practice nurses, in that these differences limited the ability of the practice nurse to provide evidence-based care with any degree of consistency.

Theme three: The giving of information

Many participants viewed a role as educator and giver of information as a major component of their work, however, the contribution this makes to the overall health status of the individual with chronic conditions may not be readily identifiable. The giving of information often occurred in an unplanned, reactive manner, in response to acute or delegated nursing contacts. The provision of information was centred on the national priorities of the increasing numbers of persons being diagnosed with diabetes, and cardiovascular disease.

How the practice nurses gave information appeared to be influenced by their perceptions of their role as educator and influencer of positive health behaviour. The participants' description of this role of providing information strongly supports the suggestion that participants identified with a role in influencing behaviour change through the provision of information. Regarding information giving and knowledge levels, positive descriptions emerged of practice nurses with established collaborative relationships with specialist services, such as specialist respiratory and diabetes nurses. However, referral processes were at times difficult, due to the inability of the practice nurse to refer when she deemed this necessary, needing to request and negotiate with the GPs for their opinion and referral. This lack of autonomy limited the ability of the practice nurse to both determine the need for, and effect, referral as appropriate.

Summary

The National Health Committee paper giving advice to the Ministry of Health, on how to better support people with chronic conditions (NHC, 2005) as detailed earlier, provides key themes comparable those revealed in this study. Those to emerge from focus groups of people with chronic conditions included that family support was crucial, self management courses were a key factor, and having a good GP and nurse was seen as critical. Factors seen to hinder people with chronic conditions included poor coordination and communication in the health sector, limited understanding in the health and social sectors about the long term nature of chronic conditions, and that these individuals did not consistently get the health information they needed, and when they did, it was not always in an appropriate form.

From the perspective of the health professionals in the same study, (NHC, 2005) the main themes to emerge included the importance of the 'caring relationship' between professional and patient, the 'broker' role of health professionals, the need to work with the whole family of the person with chronic conditions, the need for better coordination to encourage self management and that the coordination in primary health care could be improved, such as with sharing of patient information. Additionally, nursing was viewed as requiring up-skilling in order to case manage people with chronic conditions, there was an identified need for better sharing of information using technology, a need for better information for patients and appropriate mechanisms for patient education, with

pamphlets not necessarily seen as the best way to get information across (NHC, 2005). The findings of this discussion paper, alongside the study of HealthWEST PHO practice nurses (Horsburgh et al, 2005) are consistent with literature examined around the key themes to emerge from this study. Of particular significance are the similar themes from the perspectives of both the individuals with chronic conditions and health professionals concerning coordination and communication, the concept of available time, and the provision of acceptable and appropriate information.

Recommendations for practice

These study findings of practice nurses' perceptions, contribute to the New Zealand literature on the role of the practice nurse in the care of individuals with chronic conditions. However, the findings cannot be generalised due to the individual and varied nature of participants' practice contexts, and the purposeful recruitment of participants (LoBiondo-Wood & Haber, 1998). It is suggested, however, that they can be considered when looking at the organisation of nursing services in the general practice setting, both now and into the future.

The use of computerised systems for the collection and structuring of information regarding individuals with chronic conditions such as diabetes as described by the participants appears advanced, but a balance is needed whereby computerised systems are utilised as supportive tools, alongside the provision of client centred care, which is enhanced by equitable relationships between nurses and individuals. A level of standardisation of computerised clinical information is required across general practices, to effect transfer of meaningful data across health care settings such as with the evolving summary care record in the UK.

In considering the concept of client centred care, a paradigm shift regarding the practice nurse role appears necessary to enable individualised nursing care determined in partnership with the individual. Client centred care has the potential to provide the individual with care responsive to evolving needs, unimpeded by prescribed sets of recommendations and rules around attendance and follow up by the general practice team. This will challenge practice nurses to question current ways of working, and consider the role of the individual as an

expert in their own lives and of their chronic condition. This will be further enhanced by recognition of the role the computerised system plays in monitoring and surveillance, but not at the expense of client centred care based upon sound relationships.

The practice nurse role regarding the facilitation of agreement of the individual to follow practice recommendations, primarily as an assistive role to the GP to gain individual attendance, was compelling. It is suggested that strong critique of the rationale and importance placed upon this occurs, and furthermore it is recommended that practice nurses consider the individual's reasons for not following these recommendations. This will further acknowledge and support the individual's right to self determination, and client centred care.

Regarding time and perceived constraints, it is suggested that by recognising the focus of care provided by the practice nurse to the individual with chronic conditions, such as with the Kaiser Permanente Model of stratification of care needs, actual and potential time constraints may be alleviated. The organisation of care into designated clinics demonstrated evidence of a level of consistency of care provided to individuals with chronic conditions, is supported by literature as contributing to improved clinical outcomes, and are encouraged as a means of addressing time constraints that could be further implemented and evaluated. Furthermore, the use of evidence-based guidelines is recommended to support the consistent provision of appropriated care to individuals with chronic conditions, however, it is evident the need exists to be able to individualise care within these.

Whilst predominantly the use of traditional didactic health education or information giving was evident amongst participants, it is suggested that acknowledgement of individuals as active participants in knowledge acquisition to support self-management, is integrated into practice. This could be achieved by the ongoing reassessment of an individual's knowledge, and continued endorsement of self-initiated sourcing of knowledge. This should occur whilst remaining cognisant of the impact of a diagnosis of a chronic condition on the individual, the necessity for information to assist in self-management, and potential for information overload and the resultant need, at times, to limit information at any given contact.

The acknowledgement of individuals as active participants in care provides specific challenges to nurses working in general practice in New Zealand, who need to incorporate educational activities such as lifestyle advice, within a perspective which incorporates the wider socio-environmental approach. This also challenges practice nurses to broaden their perspective on information giving and health education to one wider than individual behaviour change, in consideration of the wider range of factors which affect individuals' health behaviour choices. A philosophy of partnership will further support this, where individuals are recognised as experts in self management of chronic conditions. The challenge exists to maintain a balance between a supportive care delivery system, and care that is client centred.

A level of consistency regarding fundamental knowledge and skills alongside access and support to ongoing education and professional development is further recommended, to ensure the practice nurse is able to function within the scope of competent Registered Nurse. These recommendations provide the basis for further research and consideration of the role of the practice nurse in the care of individuals with chronic conditions in the New Zealand general practice context.

Recommendations for further research

While the findings of this small qualitative study are important, they by no means provide readers and policy makers with comprehensive data regarding the role of the practice nurse with individuals with chronic conditions in New Zealand. The findings themselves pose areas of potential further research into:

- The concept of time, and time management in the general practice setting
- The organisation of the work of the practice nurse including specific concepts such as dedicated clinics and case management
- Practice nurses' perceptions of the role as provider of health education within a wider focus of health promotion
- Investigation of alternative models of practice nurse delivery of care to individuals with chronic conditions, such as the implementation of 'Care Plus'. This is in line with the increased New Zealand focus on the role of the PHC nurse, and the UK NHS focus on the increasing role of the nurse in case

management and coordination of the care of individuals with chronic or 'long term' conditions.

- Individuals' perspectives of the contribution of practice nurses to their care within the context of a diagnosed chronic condition.

It is suggested that ongoing research continues in the New Zealand context, to record and contribute to the literature on the developing role of the practice nurse in the care of individuals with chronic conditions.

Limitations of this research

This was a small qualitative study with the sample made up of participants from solo, group, and accident and medical general practices. These appeared to represent the general demographics of the practice nurse population in the research area. There were no participants from Maori/iwi provider general practices. This limits the comparability of the findings to wider than mainstream general practice settings. However despite this, I believe the findings provide a useful insight into the contribution practice nurses can, and do make, to the care of individuals with chronic conditions.

The requirement of qualitative research to perform a literature search prior to commencement of the data collection could have potentially influenced my views of the area under study. To manage this the literature search was purposefully aimed at providing a broad context to begin the study within, and the limited literature available on the role of the practice nurse in New Zealand also provided some control around my preconceived ideas of the role.

I was aware of the need to manage any preconceived thoughts about the contribution of practice nurses to the area of study as a result of my fifteen year background as a practice nurse. I maintained a continual awareness of my own ideas and endeavoured to put these aside during both the conduct of the interviews and the analysis of the data.

Conclusion

This is a study of practice nurses' perceptions of their contribution to the care of individuals with chronic conditions. As described, the contexts in which the practice nurse participants' worked pose certain challenges to the fulfilment of the role of Registered Nurse. The very nature of general practice as a first point of contact primary care service, further poses challenges to the practice nurse in the fulfilment of the role of initial assessor of acute presentations to the practice, alongside regular provider of planned nursing care. The focus of care around the identified priority area of diabetes, and in the provision of repeat medication and all this necessitates, places a particular lens over many of the consultations the individual has with the practice nurse. This further limits the ability of the nurse to provide holistic health based nursing assessment, and ongoing care.

The repeatedly described perceptions of limited time contexts the practice nurses work within, alongside the practice rules around frequency, content, and format of visits of individuals with certain chronic conditions, also provides a set of controls around the work of the practice nurse. These time constraints at times limit the ability of the nurse to establish and maintain ongoing nursing relationships. It is recommended that recognition exists of the significance of provision of adequate time to support the development of these nurse-client relationships.

Practice nurses fulfil an integral role in acknowledgement of individuals as active participants in their ongoing care, and this could be achieved through recognition of an individual's right of choice regarding ongoing contact with the general practice, and as expert in their own diagnosed chronic condition. Additionally, there exists the need for practice nurses to recognise the focus of the care they provide in the general practice context as '*support of self management*', further contributing to the acknowledgement of individual's as active participants in care.

A balance is necessary, between the organisation, and structure described as provided by the computerised systems, and the provision of client centred care. This could be achieved by acknowledging the role of the computer as a *tool* to support the care provided by the general practice, not as the instigator and instructor of care.

Practice nurse participant perceptions of their educational preparation and current knowledge influenced their confidence, and in turn the level of nursing care they provided to individuals with certain chronic conditions. What is more, the referral of individuals with chronic conditions to specialist services was at times influenced by these perceptions, within the particular general practice contexts, therefore resulting in disparate referral processes. It could be argued that the practice nurse as a Registered Nurse ought to have a 'competent' level of knowledge of the described chronic conditions, to enable provision of appropriate nursing care within the general practice context. This could result in reserving referral to specialist services for those individuals with complex conditions outside of the 'competent' level of nursing skill and expertise.

Practice nurses in this study provided a rich description of many roles they undertook in the care of individuals with chronic conditions. It needs to be acknowledged that many were working in settings where the work schedule was commonly determined by the employer, commonly being the GP(s), although there were exceptions, whereby the practice nurse determined the organisation of her work. The many sub-themes described contributed to both the rationales and detail of their contribution, and were supported by international literature as legitimate processes to engage in within the care of individuals with chronic conditions. I believe this research provides a useful insight into the valuable contribution practice nurses can make now and into the future in the provision of general practice based care of individuals with chronic conditions. I am grateful to the participants who gave so willingly of their time and expertise to contribute to this valuable study.

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22 August 2005

Appendix 1: Ethical Approval

Ms Deborah Davies
16 Campbell Street
FEILDING

Dear Deborah

Re: HEC: PN Application – 05/89
Practice nurses and the care of individuals with chronic health conditions

Thank you for the above application that was considered by the Massey University Campus Human Ethics Committee: Palmerston North at their meeting held on 9 August 2005.

On behalf of the Massey University Human Ethics Committee: Palmerston North I am pleased to advise you that the ethics of your application are approved. Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

A reminder to include the following statement on all public documents: *"This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North Application 05/89. If you have any concerns about the ethics of this research, please contact Dr John G O'Neill, Chair, Massey University Campus Human Ethics Committee: PN telephone 06 350 5799 x 8635, email humanethicspn@massey.ac.nz".*

Yours sincerely

Mr Paul Green, Acting Chair
Massey University Campus Human Ethics Committee: Palmerston North

cc Ms Lesley Batten
School of Health Sciences
PN351

Professor Carol McVeigh, HoS
School of Health Sciences
PN351

Appendix 2: Flyer

Practice nurses and the care of individuals with chronic health conditions

Are you a practice nurse working within a general practice, Maori health care provider or Trust ?

Do you provide care to individuals with chronic health conditions such as Type 2 diabetes, cardiovascular disease and chronic lung disease?

How would you like to take part in an exciting study looking at your contribution to the care of those with chronic health conditions?

I am a Registered Nurse currently undertaking a research project as partial fulfilment of a Master of Philosophy at Massey University . I have fourteen years experience as a practice nurse in this region and I am interested in your valuable contribution to this research. I am particularly interested in your perceptions of the contribution you make to the care of individuals with chronic health conditions.

Would you be interested in taking part in this research project being undertaken?

If so please contact:

Debbie Davies

Researcher (as a student)

H: 06 323 4011

M: 027 688 7379

Email: krdcdavies@xtra.co.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North application 5/89. If you have any concerns about the ethics of this research , please contact Dr John O'Neill, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5799,extn 8635,email: humanethicspn@massey.ac.nz.

Appendix 3: Information Sheet

Information Sheet

Practice nurses and the care of individuals with chronic health conditions

Introduction

My name is Debbie Davies and I am a Registered Nurse presently enrolled in a Masters of Philosophy degree at Massey University. As part of my study I will be undertaking the above named research project. You are invited to participate in a study that explores the perceptions of practice nurses' of their contribution to the care of individuals with chronic health conditions. I currently work as a practice nurse and am also employed by the MidCentral District Health Board as a Practice Development Nurse working with nurses in primary health care.

Participant recruitment

- To be eligible to participate you must be a practice nurse currently working in a clinical role.
- It is likely there will be up to twenty participants in total.
- You are invited to be interviewed, where you will be asked to share with me your perceptions of your contribution to the care of individuals with chronic conditions such as Diabetes.

Participant involvement

- The interview will last approximately sixty minutes. There will be a minimum of one interview, and there may be the possibility that I speak to you further either by telephone or by a second interview.
- The interviews will take place at a time and place convenient to you outside of your normal working hours.
- The interviews will be audio-taped with your consent and transcribed in full and you will have the right to ask for the audiotape to be turned off at any time during the interview.
- The tape recordings and transcriptions will be stored securely and will only be accessed by authorised persons who have signed confidentiality agreements.
- There will be no personally identifiable features in the written transcriptions or the thesis
- The written versions may be returned to you and checked by you, if you wish, to ensure they are correct. These transcriptions will be coded and analysed as part of the study.
- There will be no financial compensation to you as a participant.

Confidentiality and participant protection

- All of the information you give me will only be accessed by myself, my supervisor and the person who transcribes the tapes. The transcriber will be required to sign an agreement of confidentiality.
- Every care will be taken to avoid the identification of any participant in the presentation of the results or in any articles, which will be published as a result of this research study.
- No information gained during the research will be shared with your employer.

Researcher obligation

- It is a requirement under the Health Practitioners Competency Assurance Act (2003) to report instances of unsafe or unethical nursing practice that compromise patient safety. If, during the course of an interview, I believe that a nurse may have disclosed issues that may have compromised patient safety I will discuss this with my supervisor and the nurse participant before proceeding.

What happens after the completion of the study?

- I will notify you of the results of the study and you will be supplied with a copy of a summary of these. You will also have access to a full copy of the thesis if you wish.
- On completion of the research you will be offered the choice of having the audiotapes of your interview that have been recorded returned to you or destroyed.
- All consent forms will be stored in a locked cabinet at Massey University, Palmerton North campus for five years.

Participants' rights

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- Decline to answer any particular question
- Request that the tape recorder be switched off at any time during the interview
- Withdraw from the study at any time up to the end of data collection
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given a summary of the project findings when the study is concluded

If you are keen to contribute to this research of practice nurses' perceptions, and/or if you have any questions about this project please contact:

Debbie Davies

Researcher

Ph: 06 323 4011 or 027 688 7379.

Email: krdcdavies@xtra.co.nz

Lesley Batten Supervisor

Ph: 06 3569099 extn: 2247. Email: L.Batten@massey.ac.nz

Ethical committee approval

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North application 5/89. If you have any concerns about the ethics of this research, please contact Dr John O'Neill, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5799, extn 8635, email: humanethicspn@massey.ac.nz.

Appendix 4: Introductory letter

Invitation to registered nurses working as practice nurses to participate in a research project.

Dear Practice Manager,

My name is Deborah Davies and I am a Registered Nurse presently enrolled in a Masters of Philosophy degree at Massey University. As partial fulfilment of the degree I am undertaking a research project with practice nurses to look at their perceptions of contribution to the care of individuals with chronic health conditions. I am writing to request your assistance to distribute the enclosed flyer to all registered nurses working within your practice.

I will not be interviewing any participants during their usual hours of work and the interviews will be conducted at a time and place mutually agreed between the participants and myself.

The practice nurses and particular general practice setting will not be identifiable in any way in the writing up of the research.

I am grateful for your assistance in gaining practice nurse interest and participation in this research.

Kind regards

Deborah Davies

Ph: 06 323 4011

027 688 7379.

Email: krdcdavies@xtra.co.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, Palmerston North application 5/89. If you have any concerns about the ethics of this research, please contact Dr John O'Neill, Chair, Massey University Campus Human Ethics Committee: Palmerston North, telephone 06 350 5799, extn 8635, email humanethicspn@massey.ac.nz.



Appendix 5: Participant Consent Form

Practice nurses and the care of individuals with chronic health conditions
Participant Consent Form

This consent form will be held for a period of five (5) years

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

- I agree/ do not agree to the interview being audio taped.
- I wish/ do not wish for my tapes to be returned to me.
- I wish/ do not wish for my transcripts to be returned to me.
- I agree/do not agree to provide information to the researcher on the understanding that my name will not be used without my permission.
- I agree/ do not agree to excerpts of my transcript being used in the produced thesis.
- I agree to participate in this study as outlined in the information sheet.

Signature: Date:

Full Name – printed:.....

Address

(for return of tapes, transcripts, summary of findings).....
.....
.....
.....



Appendix 6: Transcriber Confidentiality Agreement

Practice nurses and the care of individuals with chronic health conditions

Transcriber Confidentiality Agreement

I (Full Name) agree to transcribe the tapes provided to me for the research project:

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for this project.

Transcriber

Signature: Date:

Full name – printed

Witness

Signature: Date:

Full Name – printed

Preparing the Person for an appointment at the general practice

Recall

- What
- How
- Why
- Who - initiates

Telephone contact with Practice Nurse

Patient initiated

- Acute / routine
- Need for GP appointment
- Advice giving reassurance/ instructions

PN initiated

- Recalls / monitoring chronic conditions.
- Test results
- Need for follow-up

Influential factors

Time

- Limited
- Variable
- Paradox of trying to establish relationship
- Not protected
 - may be interrupted

Knowledge

- Core education attended
- Common vs less common
 - ↓
- Influence on knowledge & confidence level

Documentation & Communication

- Computer system taskbar
- Verbal ?
- Method of referral
 - GP → PN
 - PN → GP
- Documentation process

Relationships

- Establish with individual/family
 - > take time - paradox
- Continuity of care
 - > nurse led
 - > 'diabetes nurse'
 - > 'CVD nurse'
- Within the team
 - > hierarchy GP → PN
 - > dominance
- External to team
 - > role within wider environment
 - > referrals to others
 - > when
 - > why
 - >> lack skills
 - >> lack confidence
 - >> scope of practice

Guidelines

- What
 - > do they exist?
 - > types
 - >> written
 - >> unwritten
- How
 - > do all team members utilise?
- Why
 - > ? EBP
 - > GP rules
- When
 - > are they used?

The Practice Nurse Giving of Information

Knowledge of the Practice Nurse

- Ongoing education
- Hierarchy of knowledge
 - > GP
 - ↓
 - PN
- “Holder of Information”
 - > know more than the individual ?

Knowledge of the individual

- What
 - > does the individual know
 - > is the PN engaging in ongoing assessment?
- How
 - > do they gain information?
 - > PN/GP not only source
 - >> internet
 - >> life experience
- Role of individual in ‘education’
 - > active
 - > passive
 - > limited (?by PN)

Knowledge of the Others

- Who
 - > in practice
 - >> other PNs
 - >> GP
 - > external to practice
 - >> specialist services
 - >> voluntary services
 - >> community resources
 - >> internet
- When
 - > does PN recognise scope of knowledge & need to refer
- How
 - > does PN involve others
 - >> referral phone or letter

How the Practice Nurse gives information

- Limited amounts
- Prior and ongoing assessment
- Adhoc / reactive fashion
- Controls knowledge transfer
- Why does PN educate?
 - > asked to by GP
 - > huge role for some
 - > core role of PN
 - > technical task teaching

Detail

- At diagnosis of chronic condition
- Acute / unplanned visits
- Planned visits
- Delegated care

Influential factors

Time

- “Squeeze ins”
- Planned – time limits

Documentation / Communication

- At end visit
- Of referral from GP → PN

Knowledge Level of PN / Confidence Level

Relationships

- Establishment
- Continuity of care
- Trust

Care provided by the practice nurse at the general practice

Visit to the Practice Nurse

- Unplanned
 - > acute,
 - > non acute
- Planned
- Delegated care

Delegated Care

- What
 - > technical tasks
 - > "education"
- How
 - > "squeeze ins"
 - > structured?
- Why
 - > GP too busy
 - > cost of GP Vs PN
 - > do they know why?
 - > part of team
- When
 - > schedule of visits
 - > adhoc
 - > reactive Vs planned

Unplanned Care

A. Acute

- What
 - > range of chronic conditions
- How
 - > response, triage, assessment?
- Telephone triage
 - > need to see GP?
 - > advice
 - > reassurance
- Who
 - > ? others involved
 - > ?GP?

B. Non acute

- "drop ins"
- reactive response to ongoing c.c's
- adhoc nursing response
 - > absence of guidelines?
 - > policies?
- team work?
- following initial dx for some c.c

Planned Care

- What
 - > primarily diabetes
 - >> regular 'reviews'
 - >> F.A.Cs
 - > other chronic conditions ↓ often
 - > CVD screening reduce.
 - > prescription review process
 - > 'Nurse led' clinics
- When
 - > recommended/prescribed intervals 3/12, 6/12, 12/12
 - > initial dx of some chronic conditions - diabetes
 - > hypertension reviewed 3-12/12
- Why
 - > FAC
 - >> funded by MoH
 - >> individuals 'need' assistance of GP Team to learn about c.c
 - > Rx
 - >> professional responsibility of GP to Rx
- How
 - > time allocated booked appointment
 - > giving of information primarily
 - > some description of assessing Needs

Effects

Common vs Less Common Conditions

- ↑ description of common
- ↓ confidence with less Common
- Variation of nursing care

Structured vs Unstructured

- Reactive nursing care
- Technical tasks
- vs
- Planned nursing input support of individual

Individualised care

- In presence of guidelines?

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