Collaboration is the only way

Gill Regan, Registered Nurse

'Primary health care is not a set of static services but a process.'
(Don Matheson. Health Where it Hurts; 1992)

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Back to the future

Traditionally the role of nurses in general practice has been to support doctors, but this has been challenged in the practice I work for – the Newtown Union Health Service (NUHS) – and also, to some extent, with the advent of Primary Health Organisations (PHO). I am curious about how PHOs have supported changes in the delivery of care by general practice multidisciplinary teams (MDT).

Whilst the following commentary is about nursing in primary health care (PHC), nursing services cannot be viewed in isolation. This is my personal journey, my experiences and insights into what could be the PHC nurse of the future, including the challenges and possible pitfalls – and also a healthy curiosity about what might be achieved. My last 18 years has been spent developing the role of PHC nurses at the NUHS; a population-funded, community-owned, not-for-profit health service with an emphasis on health-prevention and education in which all staff are employees. Does this sound familiar?

It has been suggested that nursing is in a better position than other disciplines to provide primary health care. However, setting up health services which are dominated by any one discipline is not, in my opinion, a particularly helpful approach. I do not believe any discipline has a monopoly on providing this type of care. Services are required that need to be able to draw on the expertise of a wide range of workers, whether they are based on the premises, outreach or liaising with specialist services. The need for teamwork is paramount. According to research, health services only contribute to about a fifth of overall health improvements as these predominantly occur through changes in social, economic and cultural impacts. Liaison and networking within health, as well as social services, is essential to reduce health inequalities and improve outcomes.

Handing over control

From its outset, the NUHS model challenged the traditional role of general practices as small businesses and doctor-owned practices, and the doctor/nurse role, with doctors being the key primary health care providers. The NUHS promoted the need to provide more comprehensive care with an emphasis on health education and prevention. Its nurses are autonomous and interdependent. All NUHS staff are employed by the Policy Board representing the communities we serve, but also including representation from the staff. The board and staff have worked hard to achieve an inclusive management style; it does not just happen. We believed in the processes and continually work together to make things better. Nursing has always held a high profile in the NUHS and the service itself has endeavoured to create a model that supports the development of their potential. All nursing roles could be viewed as advanced nursing positions in a multidisciplinary team framework. Nurses operate within the principles of community development and community participation with liaison and networking with other agencies integral to their work. This high profile has meant some huge shifts in attitudes as well as some leaps of faith. Nurses have had to review how they work and find ways to expand and extend their roles. They are as responsible as anyone else at the NUHS for its successes and failures. We needed to be responsible not only for our own input but for the whole outcome, which often means that we have to step outside our comfort zone, take responsibility, take chances, give up some control and become self-starters and thinkers. This has been a challenge.

I hesitate to say – and maybe things have changed – but in my experience many nurses have found it hard going to take on the expected responsibilities and challenges of being equal team members. For many it certainly was not a part of their past nursing experiences in PHC. Many, of course, thrived in the old environment. Doctors have also been challenged in their thinking. I understand, from day one

of training, doctors are told that they are solely responsible for their practice and outcomes. To be asked to share some of these responsibilities does not always come easily. Again, some thrived, some moved on.

Time and commitment

For a group of people with different skills and backgrounds, working well in a team and getting the best outcomes as a whole requires effort, time, trust and commitment. I have discovered that being part of a team (which nurses excel at) is not necessarily the same as taking on equal responsibility of the team. Our other team players are administrators, health workers, interpreters, managers, midwives, receptionists and social workers. We are challenged to find ways to work as true colleagues, to share power and not just give lip service to the ideal. The greatest challenge has been to learn how to work for our communities, not just with them. We have learnt to listen to their needs and ideas and act upon them. Handing over control means giving up some of this ourselves, quite a different mind set.

Gaining community confidence

NUHS nurses chose to widen their skill base, be more holistic and look at the bigger picture rather than concentrating on extending their clinical skills. The first lesson we learnt was that our consumers didn't want it! Despite nurses consistently being voted by the public as the group they most trust, when it came to their health, consumers wanted to see a doctor. We needed to build relationships and trust with consumers to enable us to start independently addressing education, screening and chronic care management. To start with we saw 'sick' people with support from our doctor colleagues. We then moved into the community, work places, homes and groups and got to know our community. Time needed to be allocated for this. This gave us valuable insight into their lives and helped change the balance of relationships.

It was soon clear that there was a considerable grey area in PHC which could be seen as either nursing and/or medical, areas in which education and management were the key. These included skin care, asthma, reproductive issues, stress and so on. In the early days we found our community did not book nursing appointments very often. However, over time, improving our assessment skills and knowledge and seeing people when necessary with our medical colleagues established trust. Now, frequently, people book time with a nurse only and, at times, need to be convinced that a doctor is required.

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We are now fully accepted and able to concentrate on health management, prevention, education and coordination. We are still expected to deal with 'sickness' in an appropriate way and we have had to develop an on-the-day service for unbooked people with two nurses and one doctor. Nurses triage and incorporate opportunistic screening and education when time allows. Up to 45 people a day use this service. One third are seen by a nurse only, one third by doctor only after an initial quick triaging and the rest are seen by a nurse and a doctor. As one doctor said to me: *'It is hard work, as I only get to see the complex, time-consuming cases. The straightforward cases have virtually been completed by nurses.'* The nurse's role here is to educate, manage and troubleshoot plus, of course, to give appropriate triaging and care to unwell people. We are not involved in the after hours and weekend acute care.

Challenges of a growing health service

The service continues to be responsive to the community's need and to work collaboratively, in multidisciplinary teams. Nurses have developed special areas of interest as it became clear that we needed key workers to coordinate and focus on specific areas. To allow for continuity of care we found staff were required to be available for a minimum of three appointment sessions per week spanning our hours of opening. Areas of specialty are generally managed in smaller, cross-discipline teams consisting of appropriate personnel (community health worker, social worker, midwife, doctor, as well as the nurse). Nurses are responsible for coordinating and collaborating with other health workers in relevant community services and the community of interest. Many have become highly experienced in their areas of interest. We firmly believe that a generalist approach is the prime nursing model. We require all nurses to be aware of, and to respond to, the whole person, family members and community issues . The challenge now is how to prevent the silo approach as nurses get busier and areas of specialisation become increasingly complex (e.g. diabetes care). It will never be static. Communication, exclusivity, equability, quality and teamwork all become more difficult as we grow bigger.

Education is a major issue. Training for PHC nursing has been ad hoc at the best and, while improving, is still unstructured at the generalist level and leaves much to be desired, especially when we argue the case for equity in PHC. There is an urgent need for training that focuses on multidisciplinary teamwork providing care to people within a community development model for all PHC workers. This is also a challenge for funders and providers of education for health workers.

New roles, responsibilities and challenges

One model is unlikely to suit all New Zealand at present. The business model of health is well established

and, whilst I would argue for a change in direction, the reality is that we will have to work with what we have for some time yet in general practice. For nurses employed by doctors, decision making will be problematic. The control nurses have over their service delivery will depend on management systems and the funding of PHC services. Interestingly, information from the Ministry of Health states that, at present, nursing consultation data at the practice level is poorly captured at a national level. So much of nursing is invisible.

The NUHS, being a population-funded, community-owned organisation, allows for the community and all disciplines to be fully involved in all decisions, within the constraints of its philosophy and funding. There are, however, still constraints in community-owned systems. In my experience, we cannot assume that health workers will have the necessary skills to work in an interdependent, collaborative model. There are a multitude of reasons for this but training is the key.

Know thyself

The challenge is to offer services with no gaps and to have excellent communication with other providers. But a key question is, will this occur if nursing services isolate themselves from medical services? It may be possible to second nurses to general practice, but for this to be well coordinated and for continuity of care, it would require an ongoing relationship and collaboration between nurse and doctor. This may be improved if the doctor does not directly employ the nurse – but I doubt if this can be assumed. Some PHOs have employed 'access' and 'care plus' nurses, who work from outside the practice environment. What has been learnt from this with regard to coordinated care?

The hard questions

Much of nursing is about communicating and liaising with consumers, but do we communicate well amongst ourselves? How many nursing discharge/consultation summaries do you see on your consumers' files from other agencies? Do you all know which nurse, midwife or other health worker is in contact with your individual consumers and what their interventions or inputs are? Are nurses resourced sufficiently to support adequate communication, training, time, space and IT with appropriate software?

I am interested to see how the Nurse Practitioners (NPs) will be absorbed into PHC both financially and practically. Many NPs become specialists; a great fit. However, as previously mentioned, specialisation can undermine holistic care due to pressure of workload. It may well work more satisfactorily in a larger PHO environment as long as excellent communication is achieved with other providers.

NPs with prescribing rights will face the challenge of not being used as 'another doctor' both by employers and by consumers and may find themselves with limited time to address areas such as prevention management. At the NUHS we have found that at our OTD drop-in clinics so much time is consumed by 'sickness' that less and less time is available to address opportunistic education screening and social issues.

Will the general practice remain the core business of the doctor and how will care be delegated to the NP? If NPs become business partners how might this affect their practice?

In some situations it is difficult to make nursing referrals. For example, a social worker stated that all referrals must come from a doctor. Why is this accepted? Is this a funding issue or a professional one? These decisions need to be questioned. And where is the support and funding for evidence-based research showing the best way to meet particular health goals?

Appropriate training is required in all areas of PHC, from community development to chronic care management and assessment skills – and any other health issue from 0–100 years, we get it all! We work as a member of a multidisciplinary team so why is the training of health care providers separate the majority of time? I am also curious about the requirement that nurses have to keep updating in the same areas (e.g. immunisation) whereas doctors are given autonomy as professionals to choose their areas of upskilling and retraining.

I am concerned that specialisation may become the road of least resistance and that a generalised approach will remain the domain of doctors. This would, in my opinion, be a great loss to consumers. We find the richness of a MDT both rewarding and effective.

The future

Quality health services do not come cheap, and there is a need to get smarter in how we offer services. Nurses are no more, or less, altruistic or homogenous than any other group in the community, but we do have much in common with our other colleagues in PHC. People who are attracted to work in health care, regardless of their professional background, are typically motivated to 'do good' in the communities in which they work.

Our understanding, from our community, is that they would like easily accessible, appropriate, quality services that are well coordinated without duplication or gaps. The reality is that the majority of people who have health care issues do not have the time or the desire to access multiple practitioners at various locations. The PHC strategy states that communities of the future will decide on what they want and what they need and that funding agencies will endeavour to meet those needs. This may mean looking again at the ways in which we work and not expecting the needs of the community to necessarily fit into our present systems of delivery and training. This could be a time of change for health workers. Those who embrace the changing environment may well discover exciting challenges ahead and truly discover that health care is, indeed, not static but dynamic, thought-provoking and stimulating.