New Zealand practice nursing in the third millennium:

Key issues in 2006

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Key words

Primary health care; practice nurse, teamwork

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'(It is) important to take into account the differences within a profession, as well as between professions. It is also important to take account of ideas, values and beliefs which unite people across professional boundaries as well as within those boundaries: in short to be aware of cultural systems besides those which unite at a professional level.'[1]

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Introduction

As the Primary Health Care Strategy (PHCS) continues to be implemented, the numbers and roles of primary health care nurses are increasing and diversifying. 'Primary health care nurse' is now the umbrella term for nurses working in community-based settings; a disparate workforce including Plunket, public health, school, occupational health, iwi and Pacific providers, district, prison, nurses employed by Primary Health Organisations (PHOs) in 'access', 'mobile' or 'outreach' services and practice nurses (PN).

PNs continue to remain the largest and one of the longest established subgroups of primary health care nurses.[2] However the PHCS has caused the role of the PN to evolve significantly and rapidly. Despite this, the role continues to be characterised by the unique interprofessional relationship held with general practitioner (GP) colleagues with resulting outcomes to patient care from working in this team. This paper attempts to position practice nursing in 2006, acknowledging its history while looking to future challenges.

Background

PNs have worked in New Zealand practice for many years. The introduction of the practice nurse subsidy in 1970 saw the number of PNs increase considerably, at first largely being used as an assistant to the GP. Resulting images of the PN as 'doctor's hand maiden' or 'just practising' impeded the move to the professionalisation of the role, which is typically characterised by the development of a specific body of knowledge and skills. In 1998, the Ministerial Taskforce on Nursing noted that the value of practice nursing was still to be realised and that both the 'employment' status and payment structure created barriers for PNs to expand their roles.[3]

The PHCS has been the most significant policy change to influence the work of PNs.[4] Following its release, and to enable the activation of the primary health care nursing workforce, the Expert Advisory Group on Primary Health Care Nursing was contracted by the Ministry of Health (MOH) to advise on future directions. A document scoping primary health care nursing *Investing in Health: Whakatohutia te Oranga Tangata*, resulted from their work and was published by the MOH.[5] Although identifying the scope and development of primary health care nursing as a specialty, it does not explicitly *'...promote the successes of the general practice team...or understand the already existing generalist specialty of the Practice Nurse.'*[6]

What is practice nursing?

In 2005 the New Zealand Nurses Organisation (NZNO) defined the PN role to be:

'A Registered General or Comprehensive Nurse whose main focus is Practice Nursing in

(a) the delivery of Practice Nursing services in the Primary Health Care setting and/or

(b) the facilitation of educational and professional development of Practice Nurses."[7]

PNs are generally understood to work within a general practice setting, providing a comprehensive range of primary health services, and are regarded as an essential part of the general practice team.[8,9] The essence of practice nursing is generally understood to include maintaining wellness with a focus on health promotion, prevention of disease and early detection and treatment of illness. What positions the uniqueness of the role from other nursing roles is the inherent collaboration that exists between the PN and the GP. Lowrey explains this as the *'...ideal model of care focusing on delivering patient centred care and the promotion of health."*[6] Similarly Carryer et al. acknowledge the importance of having mechanisms which *'...will best ensure primary health care nurses and medical practitioners work in a way that complements the distinct contribution that nursing and medicine make in the sector."*[8]

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Practice nurses in 2006?

If you were to ask PNs what they see as being the positive aspects of their role in 2006, they might include:

A population-based approach that has been brought to primary health care to address health inequalities, increase access and coordination of services. As a result there has been an increased focus on maintaining 'wellness', with allocated funding for health promotion activity. PNs believe health promotion to be key nursing work. Dedicated funding legitimises and allows extension of this health promoting role. As well as what might be termed 'usual' PN activities and despite specific preparation for these roles, new PN-led clinics are evolving for preventative, maintenance and chronic illness management activities. Examples of such funded clinics are those for managing diabetes annual reviews and assessing cardio-vascular risk as well as those with a well-health focus. Specific funding streams such as CarePlus have influenced the roles of some PNs in chronic illness management. As well, there are a growing number of PN (specialists) with responsibilities to provide care, using evidence-based clinical practice guidelines for populations of people with diabetes and cardiovascular disease. Other initiatives such as the MENZB immunisation campaign have been jointly undertaken by primary health care nurses, particularly public health nurses and PNs.

The implementation of capitation funding (replacing the General Medical Services–GMS and practice nurse subsidy) has placed emphasis on the primary health care team to maintain health, not just on the GP role. Teamwork maximises the distinct disciplinary characteristics of team members, and when members work collegially and collaboratively, causes a combined, enhanced effect. PN and GP clinical work sits along a health care delivery continuum. The focus of PN work has been characterised as the promotion and maintenance of 'wellness', whereas GP work focuses on the diagnosis and treatment of illness; however, these aspects should not be seen as exclusive or as stereotypes of clinical work. There are many examples of effective teamwork between PNs, GPs and other primary health care professionals. Local initiatives include: sequential PN followed by GP consultations with an individual patient and then a jointly developed treatment plan (Helen Dryden [PN] and Ruth Brown [GP] at Raumati Rd Surgery); funding streams that jointly fund PN and GP input to care for patients/families (MidCentral Health DHB Palliative Care Partnership), GP support of PN-led remote clinic (Jane Ginnane [PN] and Pat Hill [GP] at a nurse-led clinic at the Wellington Compassion Centre, Soup Kitchen), chronic illness management (Anne Davies [PN] and David Nixon [GP] at The Doctors, Masterton) and a joint GP and Nurse consultation service (Janine Vollebrect [PN] and Cath Becker [GP] at Kura Whanau GP clinic at Te KuraKaupapa Maori O Wairarapa).

As well as what might be termed 'usual' PN activities and despite specific preparation for these roles, new PN-led clinics are evolving for preventative, maintenance and chronic illness management activities

Primary health care nurses are developing political acumen,[10] and a number of organisations are actively supporting this development. Examples include New Zealand Nurses Organisation (NZNO) Primary Health Care Nurses Council; College of Nurses Aotearoa discussion email group that provides a NZ-wide avenue to discuss nursing interests; the Organised General Practice Nursing Alliance (Inc.) and the NZNO College of Practice Nurses (more on this later).

There has been an increase in the number of primary health care nurses including PNs as 'opinion leaders/champions' at District Health Board (DHB) and Primary Health Organisation (PHO) level. Primary health care nurses, including PNs, are beginning to access and undertake funded leadership training

courses such as the DHBNZ, LAMP programme.†

Some DHBs/PHOs are considering directly employing PNs (and also GPs) on salary.[11] Although yet to be fully tested, this may address in part the employer/employee barrier to teamwork (more on this later).

The Health Practitioner Competency Assurance Act[12] has resulted in the Nursing Council of New Zealand (NZNC) defining scopes of practice for registered nurses, amongst other requirements. This has led to a clearer definition of career pathways, including those for primary health care nurses. Augmenting the voluntary Practice Nurse Accreditation Programme established in 1998, NZNO has recently released a Professional Development and Recognition Programme to facilitate PNs' career pathways whilst meeting the NZNC's professional development requirements.[13] Increasing numbers of PNs are seeking to undertake interdisciplinary education with GP colleagues, both through short courses and at postgraduate level.[14] It is known that learning together facilitates an understanding of different yet complementary roles.[15]

Similar to the vocational choice of becoming a GP, lifestyle choices continue to make practice nursing appealing, with little shift work and the ability to work around family responsibilities. This, coupled with a defined career pathway, may increasingly attract nurses who have viewed secondary care careers preferentially in the past. New graduate registered nurses are considering primary health care nursing and practice nursing as a specialty career choice. New graduate registered nurse programmes are increasingly including rotations through general practice with mentorship and professional development supplied by the local DHB. At least one undergraduate training provider is undertaking a training stream to lead nurses straight into a career in primary health care nursing.[16]

There is huge variability in how the work of PNs is conceptualised both by health professionals in primary and secondary care, but also by PNs themselves

Finally, the challenge, attraction and strength of general practice,[17,18] remains in its ability to provide first-point-of-contact care for those with undifferentiated illness, to give continuity of care and have longitudinal relationships with patients over many years and with generations of (extended) families. Both PNs and GPs (and patients/families) highly value this work and these relationships and, as a result, satisfaction with patient care is high and generally staff turnover is low. Frustrations appear to be largely due to the health system and structural issues.

But there are issues for practice nurses which need resolving:

Particularly pressing is the current pay differential between primary and secondary care nurses. Increasing pay differences are causing PNs (and other primary health care nurses) to consider leaving their chosen role and work in secondary care. By July this year, primary health nurses will receive $160 a week less than their secondary care colleagues.[19] It is hoped the current action by the NZNO by way of the negotiation for a Primary Health Care Multi Employer Collective Agreement will result in pay parity.

Unfortunately, not all nursing students are being exposed to general practice as a career option

Despite some PHO and DHB boards having primary health care nurse representatives, many others do not. This limits the opportunities for nurses to have influence in local health policy and service provision direction. The current NZ situation has a similarity to the 1990s' UK primary health care reforms, when potential opportunities for primary health care nurses were opened via government policy changes. However, structural impediments (funding streams and general practice work arrangements) to realise these opportunities were said to be largely not addressed, with nursing holding a *'complex and ambiguous position...the subordination and the devaluation of nursing care not (having) been swept away.'*[20]

Although capitation funding is designed to support the most appropriate member of the team to care for a patient's professional needs (potentially allowing for the expansion and recognition of the PN's role), the reality is that this money is still tagged to the GP.[13] In financial terms PN activities are not valued equally with GP activities (e.g. ACC payments). Neither is PN activity easily accounted for by PHOs or individual practices, with significant variability in the recording of nurses' clinical work on practice management systems. Except for PNs who are registered to undertake cervical smears and sexually transmitted infection swabs, other nurse-initiated laboratory screening tests and NIR records of immunisations require a stated GP as provider, rather than the initiating PN. Many PNs say they see little more opportunity from capitation funding now than prior to the introduction of PHOs; this had led to frustration in regards to role expansion.

† The Leadership and Management Programme (LAMP) is an initiative of District Health Boards New Zealand (DHBNZ). It is designed for people across the whole health sector and is an integrated programme to build long-term leadership and management skill within the New Zealand health sector.

There is huge variability in how the work of PNs is conceptualised both by health professionals in primary and secondary care, but also by PNs themselves. Roles undertaken by individual PNs in the same general practice and between PNs in different general practices are vastly different. This seems largely driven by the GP employer, although PNs themselves may constrain their role development by being unable to clearly articulate the philosophy underpinning their work[21] and instead describing it by the task they perform. There are also differences in the approaches to, and roles of, PNs in privately run general practices compared with those in third sector organisations such as union health clinics.[22,23]

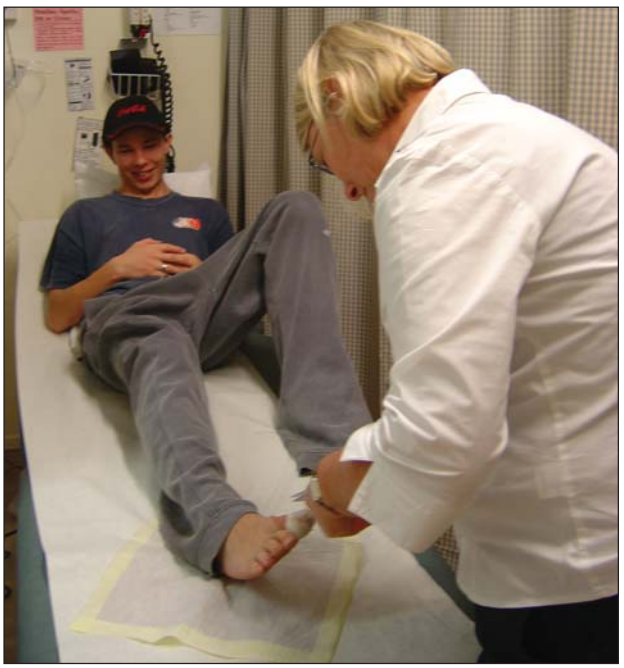
In comparison to secondary care, PNs have not traditionally had an infrastructure providing leadership and peer support. Management Services Organisations, (as did Independent Practitioner Associations), predominantly support GPs, and there is variability in how well they support PNs. Structures to support professional development such as continuing nursing education, mentorship/preceptorship, peer review meetings and professional supervision are not routinely provided. Similarly, the Royal New Zealand College of General Practitioners has held a strong role in providing GPs vocational and continuing education whereas, through lack of funding, the College of Practice Nurses has not held this mandate. Despite this, the College of Practice Nurses provides a focal point for PN information and activity.[19] There is variability around NZ whether DHBs have established Director of Nursing – Primary Care positions to provide leadership for primary health care nurses. Not having Director of Nursing positions is a significant barrier to providing an avenue for PNs to network and access opportunities for study and professional development.

PNs are part of an ageing workforce. Fifty-four per cent of all primary health care nurses in 2001 were aged between 40 and 54 years.[2] There are barriers to succession planning. Until recently few DHBs have run new graduate programmes for registered nurses to enter straight into practice nursing as a speciality. PNs themselves are divided as to whether a registered nurse should have previous graduate hospital experience before becoming a PN. Unfortunately, not all nursing students are being exposed to general practice as a career option.

There is an undisputed need for funding for professional development in primary health care.[24,25] Both PNs and GPs have been disadvantaged by lack of traditional funding streams (Clinical Training Agency [CTA] funding). Secondary care nurses' contracts include funding for professional development, yet primary care nurses contracts (including PNs) whose work is also funded by DHBs, do not. PHOs have largely not yet considered this their responsibility. Thus funding for PNs to undertake professional development and formal postgraduate programmes is limited. Whilst some GP employers have willingly supported PN professional development with some contracts including up to five days a year study, others have not.

Figure 1. Examining a child with a high fever

Figure 2. Managing wound care following minor surgery



Additionally some programmes of study for PNs have not been eligible for funding by MOH primary health care nursing scholarships. Until recently, access to, and provision of specific education for PNs has been limited to short courses to acquire skills directly relating to clinical practice. Such courses have not necessarily been linked to the NZQA framework and have not led to a coherent educational pathway for PNs. Similar to GPs undertaking postgraduate education, study is usually undertaken in a PN's own time and, if able to leave the practice for a day,

their positions have not been able to be covered because of practice funding constraints and difficulty in finding PN locums.

There is an increasing focus on the number of PN 'certificates' having to be annually maintained such as 'vaccinators' and 'smear taking' certificates. The demands of meeting these requirements seem beyond what is required of other primary health care professionals. As well as creating an administrative nightmare ensuring currency and workforce planning, it inhibits the PN's ability to focus on undertaking other professional development.

With increasing PN roles there is a need for increased physical space in general practices to consult with patients, undertake clinics and utilise information technology. Hot desking/rooming is common with PNs (and GPs) both sharing the use of the same consultation and office space and squeezed into areas which compromise optimal patient consultation.

There is very limited research activity into the work and outcomes of primary health including that of primary health care nurses, PNs (and GPs). This is a significant issue for PN further development. There are increasing numbers of new initiatives demonstrating effective PN/GP teamwork as well as PN-led initiatives, which require a rigorous evaluation and dissemination of results. Practice nursing's contribution to performance indictors such as screening and immunisation targets and ambulatory sensitive hospitalisation and chronic disease management seems to be overlooked by health research funders/evaluators such as DHBs and the MOH. The current definition of certain performance indicators of quality primary health care, such as laboratory estimations and prescription of certain medications, does not explicitly include and account for the value of PN work.[26]

Finally, the 'employee' status of many PNs is perceived as a barrier to effective teamwork. Crampton, Davis & Lay-Yee, reporting on research undertaken in 2001, described PNs as being *'hostage to the fortunes of their GP employers'* resulting in being *'...disempowered because of their status as employees of GPs, therefore hav(ing) limited opportunities to construct new roles for primary care nursing in response to the shift to population based primary care...'* They went on to question whether PNs can truly function as equal members of the primary health care team *'when one member of the team employs others in the team.'*[22]

Are these statements relevant in 2006, when PNs have supposedly more opportunities to extend their role? It appears that there is variability across NZ in how well teamwork is 'working'; with differences between large and small practices, rural and urban areas and between the North and the South Islands. PNs still report being used as receptionists and doctors' 'hand maidens' and not being able to undertake triage, advanced assessment and health management planning. This is a complex issue[27,28] and not one that can be unpicked in this paper. It seems that power neutral teamwork is more difficult to implement when some team members are employees, although anecdotally there are plenty of exceptions where individual good practice organisation overcomes this barrier. It has been suggested that teamwork is easier to achieve in third sector primary care services where all health professionals are equal employees.[22,23] A planned approach[29,30] and a social justice philosophy of patient care, which promotes an egalitarian approach to collegial relationships,[31] seems to enhance teamwork. Again this reinforces the need for research to identify the characteristics of effective teamwork. Once undertaken, it may be that these characteristics could be implemented through a focused approach by a funding/governing/stakeholder body such as the MOH or DHBNZ.

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Conclusion

Practice nursing in NZ today is a pivotal primary heath care nursing role. Changes arising from the implementation of the PHCS increase the possibilities of a career pathway including advanced roles for PNs. Effective collaborative and synergistic teamwork, which values and utilises the differing skills of PNs and GPs to the benefit of patients, is the hallmark of general practice. However teamwork does not 'just happen'; it is an intentional process which requires strategy, financial input and the building and maintenance of professional trust and respect. Although there are examples of innovative PN work and effective interprofessional teamwork, there remain a number of significant professional and systemic structural barriers which impact on PNs' ability to work effectively and equally within a general practice team. There is an increasing urgency for primary health care stakeholder organisations to address these issues.

Acknowledgements

I appreciate the guidance and information received from my interdisciplinary colleagues who include: Anne Brinkman, Jackie Cooper, Tony Dowell, Helen Dryden, Julia Ebbett, Jill Lowrey, Lynn McBain, Cathy Mitchell, Shona Old, Sue Pullon.

Competing interests

None declared.

References

1. Williams A. Nursing, Medicine and Primary Care. Buckingham: Open University Press; 2000, p.42.
2. New Zealand Health Information Service. Primary Health Care and Community Nursing Workforce Survey – 2001. 2003. http://wwwnzhisgovtnz/publications/community-nursing-surveypdf Accessed 17/3/06.
3. Ministry of Health. Report of the Ministerial Taskforce on Nursing. Wellington: Ministry of Health; 1998.
4. King A. The Primary Health Care Strategy. Wellington: Ministry of Health; 2001.
5. Expert Advisory Group on Primary Care Nursing. Investing in Health: Whakatohutia te Oranga Tangata. Wellington: Ministry of Health; 2003.
6. Lowrey J. What can practice nurses do to innovate their practice? Wellington: Victoria University; 2004.
7. New Zealand College of Practice Nurses. NZNO rules (Practice Nurses). May 2005, p.3.
8. Carryer J, Dignam D, Docherty B, Lightfoot R. The nursing answer to inequalities in primary health care. 2001. http://wwwnurseorgnz/primary_health/phn_inequalitieshtm accessed 17/3/06
9. Docherty B. Nursing in general practice: a New Zealand perspective. Christchurch: The Caxton Press; 1996.
10. Dubbeldan L. We are all nursing leaders. Pract Nurs 2005;5(2):1.
11. Greenslade A. Practice nursing - A PHO salaried model; http://wwwnurseorgnz/primary_health/phn_salary_modelhtm accessed 17/3/06 2004.
12. Health Practitioners Competence Assurance Act 2003. In: http://wwwlegislationgovtnz/browse_vwasp?content-set=pal_statutes accessed 21/3/06.
13. Minto R. Practice nurses as providers – creating a future. Kai Tiaki Nursing New Zealand, 2004; July:14–6.
14. Pullon S, Fry B. Interprofessional education in primary health care. Is it making a difference? J Interprofessional Care 2005; 19(6):569–79.
15. D'Amour D, Oandasan I. Interprofessionality as the field of interprofessional practice and interprofessional education: an emerging concept. J Interprofessional Care 2005; May (Supp 1): 8–20.
16. Bradshaw W. Primary education pathway in nursing education. Primary Focus 2 Conference; Wellington; 2005.
17. Starfield B. Primary Care. In. New York: Oxford University Press; 1992.
18. McWhinney I. Primary Care: core values. Brit Med J 1998; 316:1807–9.
19. New Zealand Nurses Organisation. 2006. http://www.nzno.org.nz/ accessed 24/4/06
20. Davies C. Political leadership and the politics of nursing. J Nurs Manage 2004; 12:235–41.
21. Gordon S. Advocating nursing. Aust Nurs J 2005; 12(10):14–7.
22. Crampton P, Davis P, Lay-Yee R. Primary care teams: New Zealand's experience with community-governed non-profit primary care. Health Policy 2005; 72:233–43.
23. Regan G. Collaboration is the only way. NZFP 2005; 32(6):375-7.
24. McKinlay E, Pullon S. Professional development in primary care-who is responsible? Kai Tiaki New Zealand 2004; July:12-5.
25. Pullon S, McKinlay E. Towards a culture of supporting professional development for primary care professionals. New Zealand Family Physician 2004; 31(4):267-70.
26. Ministry of Health. Clinical performance indicators for PHOs. 2003. http://wwwmohgovtnz/mohnsf/0/EC272299ECCBF6E1CC256C4F00028D15/$File/CPIsforPHOspdf accessed 25/4/06.
27. Davies C, Finlay L, Bullman A, eds. Changing practice in health and social care. London: The Open University; 2000.
28. Opie A. Thinking teams, thinking clients. New York: Columbia University Press; 2000.
29. Hansten R, Washburn M. Toolbook for health care redesign. Maryland: Aspen Publishers; 1997.
30. Mickan S, Rodger S. Effective health care teams: A model of six characteristics developed from shared perceptions. J Interprofessional Care 2005; 19(4):358–70.
31. Boutain D. Social justice as a framework for professional nursing. J Nurs Educ 2005; 44(9):404–9.