Practice nurses' experiences of the Care Plus programme: A qualitative descriptive study

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ABSTRACT

In 2004 the Care Plus programme was introduced into Primary Health Organisations (PHOs) in New Zealand, highlighting a new way in which chronic care could be managed within the general practice setting. This programme suggested that practice nurses could become more involved in chronic care management. However, for many New Zealand practice nurses this is a new role. The aim of this small qualitative descriptive pilot study was to describe the experiences of practice nurses delivering the Care Plus programme within the general practice setting. This study, carried out prior to the larger Care Plus implementation review (2006), provides an insight into the nursing experience of implementing Care Plus and provides a basis for future studies with regard to the nurse's role within the Care Plus programme.

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Introduction

The incidence of people with chronic health conditions in New Zealand and worldwide is increasing and this will continue to grow as the population ages.[1,2,3] In New Zealand, it is estimated that approximately 80% of health care funds are spent on treating people with chronic conditions; this increases to approximately 95% in the care of older adults.[4]

Primary health care services in New Zealand and overseas have traditionally focused on treating acute illness, with little planning of services to meet the needs of people with chronic illness.[5,6,7]

In July 2004 the Care Plus programme was introduced as part of the Primary Health Care Strategy.[8] The programme provides targeted funding to Primary Health Organisations (PHOs) for services to improve the management and care of people with chronic health conditions.[9] New Zealand PHOs are receiving an extra $20 million to provide Care Plus services, which is intended to be used to support an enhanced general practice approach in the provision of services, encouraging the participation of all team members.[8]

Care Plus involves an initial assessment and development of a care plan. Follow-up visits every three months provide ongoing support and monitor progress. These visits are either free or low cost. Enrolment in the Care Plus programme allows the patient to have a better understanding of their health condition, and access to a range of health professionals for information, support and guidance in making and sustaining lifestyle changes to improve their health.[8]

Literature supports an increased role for nurses within a team providing chronic health care[1,4,10,11] with nurses well placed to provide supportive care complementing the role of the doctor and other members of the team.[4,10] Prior to the commencement of the Care Plus programme, practice nurses had played a minor role in the management of chronically ill patients. In New Zealand it is generally the general practitioner (GP) who employs the practice nurse and determines the scope of nursing and nursing resource within the practice, which has generally led to the practice nurse working as an assistant to the busy GP, supporting the doctor in their work. While teamwork is essential to the management of patients with chronic illness, practice nurses have often been underutilised, taking blood pressures and putting patients into rooms, rather than being used to provide education and encourage self-man-

agement for patients with chronic health conditions.[11]

Care Plus has provided the opportunity for practice nurses to extend their practice into chronic care, as demonstrated during the pilot phase. The programme has enabled nurses to increase their input into patient care and make a positive difference in the health of those with chronic health conditions, however little is currently known about practice nurses' experiences of this new programme.

Methodology

The aim of this small pilot study was to describe the experiences of practice nurses in delivering the Care Plus programme within the general practice setting. As a secondary aim it was hoped that the factors that acted as barriers for implementation of the programme by practice nurses would be identified. Ethical approval was gained from the Auckland University of Technology's Ethics Committee and informed written consent was obtained from the participants.

Participants were obtained through purposive sampling. For inclusion in the study participants had to be experienced practice nurses who had been working general practice for at least three years, had been delivering the Care Plus service for at least three months and were currently working within an urban PHO in Northland. Three practice nurses aged between 40 and 60 years of age who had been working in general practice for 10–23 years agreed to participate in the study. Unstructured interviews were conducted from May to July 2005, with each participant initially being asked a broad open-ended question *'Tell me about your experiences of delivering the Care Plus programme in general practice?'* Additional open-ended questions were asked to gain further information or to clarify certain aspects of their story.

The interviews were audio taped and transcribed verbatim. Each participant was given a copy of their transcription to check for accuracy and given an opportunity to remove or change any data should they wish. The data was analysed using Boyatzis's framework for thematic analysis.[12] Initially seventeen subthemes were identified and these were grouped into three main themes. These themes and subthemes were reviewed by the research team and following discussion the number of main themes was increased to four.

Results

The four key themes that emerged were: 'a new way of working', 'being prepared', 'having enough time' and 'changing attitudes and expectations'.

A new way of working

'A new way of working' describes how the participants had to change the way they worked when implementing the Care Plus programme. The implementation of Care Plus involved participants in undertaking independent nurse-led clinics with Care Plus patients. The nurses believed that these clinics enabled them to use their knowledge and skills in ways that they had not done previously.

'I feel you are actually nursing and you are not just ushering patients into the room and doing their blood pressure and weight.'

The participants found that they began to access other services in the community that they had not previously used and they felt this would benefit their Care Plus patients. To work successfully, other staff needed to be educated about the programme and what it involved, and, by taking time to do this, the nurses felt more supported.

'Initially I thought that this is not going to work unless people around me know what I'm doing and I need the closed door in the room with the patient. So it was really all about educating staff and saying no phone calls in that time.'

The participants felt that the Care Plus programme allowed the GPs to acknowledge and appreciate the nurse's knowledge and skills and that these could then be utilised for more effective chronic care management. They believed that their role with Care Plus patients complemented those of the GPs, enhancing teamwork with the doctors, which was invaluable to their 'new way' of working.

Being prepared

'Being prepared' describes key areas of preparation that the participants felt were necessary as they started to implement the Care Plus programme. This involved creating an environment conducive to the smooth running of the programme which incorporated 'having adequate pre-start information', 'having an adequate physical environment', 'developing material resources' and ensuring adequate 'education for practice nurses'.

As this was a new role for the participants they required information about how to implement the programme, and what to cover during a Care Plus consultation. The participants felt unprepared and thought that they could have been given more support prior to commencing. Education, training and support are prerequisites for nurses when undertaking a new role.[13]

'I found it really hard to start with. I was left wondering what the heck you were supposed to cover in each (Care Plus) consultation. I just found there was no strategy, no plan.'

'Having an adequate physical environment' was also seen as important. This involved having a private room for the consultation, a computer to access the patient notes and uninterrupted consultation time. Many practices, although purpose built, do not have adequate consulting rooms for both GPs and practice nurses, which was problematic as one nurse explained:

'We were trying to work around having clinics where room was available. Room for doing interviews, having computers available, not being interrupted by telephones – these things we have to consider.'

Alongside an adequate physical environment, the participants also described the need for 'developing

material resources' so that they were adequately prepared for implementation of the Care Plus programme. Each participant outlined how they had collected resources such as pamphlets and diet sheets, which could be shared with patients during the Care Plus consultation. This appears to be an ongoing process where the nurses continued to look for resources that they could utilise.

It has been observed that the education of practice nurses is very variable with some nurses practising with little post-registration education or training.[13,14] Evaluation of the Care Plus pilots found that success of the Care Plus programme hinged on ensuring that practice nurses were confident to implement the Care Plus programme; this meant providing extra support and education for those nurses who were initially hesitant[15] and this was reinforced by the nurses in this study.

Having enough time

'Having enough time' relates to the participants ensuring that they were given adequate time to deliver the Care Plus programme. This involved having enough time to prepare for the consultations and ensuring adequate time to spend with the patient during the consultation. The participants felt more confident during a Care Plus consultation if they had time to prepare prior to the consultation. Reviewing each patient's health information prior to the consultation gave direction in regard to what to cover during the consultation.

All the participants felt it was vital to have uninterrupted time with the Care Plus patients. When the nurses started implementing the Care Plus programme the other staff continued interrupting each nurse as they had done previously, which the participants found very distracting. The nurses found that setting aside time for a Care Plus clinic was easier than trying to fit consultations into their usual working day.

Learning to manage time, particularly being able to keep to appointment times when running the Care Plus clinic, was seen as important by the participants who had never run a nurse-led clinic before. Time management was a strategy they felt they needed to learn to successfully manage their consultations.

'I am a lot more aware now of the actual time and really if I am noticing it is getting close to the hour then I do try and wrap it up because I am aware and do try to keep to time.'

However, despite these challenges the participants felt that the Care Plus programme allowed adequate time to explain things to patients and ensure that education was pitched at a level that the patient could understand.

A new approach for patients

The Care Plus programme not only meant changes for the nurses but also for their patients. The fourth theme, 'a new approach for patients' describes how patients enrolled in the Care Plus programme came to realise the important role that practice nurses have in their care and the improvements in their knowledge and health when the nurse became involved. The participants described how they found that patients' expectations changed in regard to the service offered to them by the general practice, the roles of the members of the practice team and how they managed their illness. Most patients were used to coming to see the doctor only when they were unwell, therefore encouraging them to come in to see the practice nurse rather than a doctor when they are well required a change for patients and they needed encouragement to do this.

'Before you used to get "I'm not here to see the nurse I'm here to see the doctor". Now you don't get that so much. Instead they are starting to see they have quality time with a health professional and they don't have to pay. That is a big change.'

However, once enrolled in the Care Plus programme the nurses felt that patients came to appreciate the new and extended role of the nurse. To ensure the success of the programme the participants felt that it was important to have an optimum relationship with patients, whereby each patient felt comfortable to discuss any problems they were having, and this is supported by Wiles who described that when patients felt that nurses were approachable, supportive and easy to talk to, this contributed to the success of the chronic care programme being delivered.[13]

The practice nurses in this study described how at follow-up appointments they were starting to see improvements in the health of the patients, which they believed may have related to improved patient understanding of their health conditions and medications, greater commitment to taking medication regularly, changes in diet and increasing exercise.

Discussion

This study highlights that successful implementation of the Care Plus programme involves changes in how the nursing role is perceived and supported within general practice.

The variability of practice nurses' knowledge and skills is well recognised in the literature.[4,14,15,16] It has previously been identified that nurses working in an expanded role in the care of people with chronic health conditions need education and training to support them in this new role, and this is supported in this study. Practice nurses need to be given the opportunity to identify the areas in which they feel they want further education and support, and have education directed specifically at supporting these educational needs.[13] The Care Plus implementation review noted that training in chronic care assisted nurses implementing the Care Plus programme.[17]

Getting the right staff involved at a practice level was seen as most beneficial to effective implementation of Care Plus in the pilot evaluation,[16] and this was supported in this study. This study calls for the development of Care Plus practice nurse champions, who can act as resource nurses within their individual general prac-

tices, encouraging and supporting other practice nurses working in the programme. Having a key person at PHO level to assist these nurses with Care Plus implementation is advantageous. The development of Care Plus peer support groups where practice nurses can meet and share their experiences and resources may also be important for the ongoing success of the Care Plus programme. The current PHO environment is positioned well to support this.

The findings of this study also suggest that prior to Care Plus implementation, planning is required to ensure that practice nurses will operate effectively in this role. Practice nurses need consultation space and dedicated time free from interruptions to see their Care Plus patients. Without these, the nurse's efforts to deliver the service are hindered. Innovative ways of working are required within the general practice to make use of available resources such as consultation space. In future this may mean holding group sessions for Care Plus patients as suggested by Boyd.[4] There needs to be a sharing of information regarding innovative models of implementing Care Plus across the country so that general practices implementing the programme can choose a model best suited to their situation.

The concept of teamwork between the GP and practice nurse is seen as an important part of the Care Plus programme. The participants in this study acknowledged increased teamwork had occurred with the practice nursing role now complementing that of the GP. This relationship needs to be encouraged and enhanced to ensure that the expertise of both health professionals promotes optimum outcomes for people with chronic health conditions. Differing funding arrangements have tended to discourage integration with other primary health care professionals[15,17,18] and this can be a barrier to patient referral. These barriers need to be minimised so that health professionals working within the primary health care sector communicate better and work together as part of a multidisciplinary team for improved patient outcomes.

Historically, practice nurses have played a minor role in the care of chronically unwell patients. However, Care Plus encourages patients to come in and see the general practice team when they are well, which has resulted in an increased input from practice nurses. This study indicates that patients are beginning to see the benefits of general practice teamwork and the skills and expertise the practice nurse has to offer, which was supported in the Care Plus implementation review.[17] To ensure ongoing funding of the Care Plus programme it is imperative that data is collected to show that the impact of practice nurses in assisting chronically unwell patients improves their health.[4] This small pilot study provides a starting point for more rigorous evaluative research.

Further research is needed to explore the experiences of a wider group of practice nurses, especially those who do not identify as European and those who work in rural areas. However, this study has highlighted the important role practice nurses play in the provision of Care Plus services. It has also demonstrated that for the continued success of the programme, attention needs to be given to the development and education of practice nurses for the expanded role, planning and teamwork within general practice, and changing staff and patient expectations in relation to the role of the practice nurse in chronic care management.

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Competing interests

None declared.

References

1. Cumbie S, Conley V, Burman M. Practice nursing model for comprehensive care with chronic illness model for promoting process engagement. Adv Nurs Sci 2004; 2 (1):70-80.
2. Groves T, Wagner E. High quality care for people with chronic diseases. BMJ 2005; 330 (7492):609–610.
3. Whelan J. WHO calls for countries to shift from acute to chronic care. BMJ 2002; 324:1237.
4. Boyd M. Chronic rethink. Nurs Rev. 2005; 6:13–14.
5. Brown FM 3rd. Inside every chronic patient is an acute patient wondering what happened. J Clin Psychol. 2002 Nov; 58(11):1443-9.
6. Glasgow R., Orleans T, Wagner E. Does the chronic care model serve as a template for improving prevention? Milbank Q 2001; 79(4):571–612.
7. Walsh M, Crumbie A, Reveley S. Nurse practitioners: Clinical skills and professional issues. Oxford: Butterworth-Heinemann; 1999.
8. Ministry of Health Primary Health Care Team. Care Plus – for high needs patients. The Practice Nurse 2004; 4(2):14.
9. Ministry of Health. Care Plus: An overview. Retrieved 1st June, 2005 from http://www.moh.govt.nz.
10. Lubkin I, Larsen P. Chronic illness: Impact and interventions. 5th ed. London: Jones and Bartlett Publishers International; 2002.
11. Bodenheimer T, MacGregor K, Stothart N. Nurses as leaders in chronic care. BMJ 2005; 330:612-613.
12. Boyatzis R. Thematic analysis and code development: Transforming qualitative information. California: Sage Publications Ltd; 1998.
13. Wiles R. Empowering practice nurses in the follow-up of patients with established heart disease: lessons from patient's experiences. J Adv Nurs 1997; 26 (4):729–735.
14. Richardson A, Cunliffe L. New horizons: the motives, diversity and future of 'nurse led' care. J Nurs Manag 2003; 11:80-84.
15. Ministry of Health. Investing in health: Whakatohutia te Oranga Tangata. A framework for activating primary health care nursing in New Zealand. Wellington: Ministry of Health; 2003.
16. CBG Health Research Ltd. Care Plus process report. Retrieved 5th June, 2005 from http://www.moh.govt.nz.
17. CBG Health Research Ltd. Review of the Implementation of Care Plus. Retrieved 30th August 2006 from http://www.moh.govt.nz.
18. Atkin K, Lunt N. The role of the practice nurse in primary health care: Managing and supervising the practice nurse resource. J Nurs Manag 1996; 4(2):85–92.