

Consumer Perceptions of Practice Nurses

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ISBN 0 909756 78 3

1. Nurse practitioners – Queensland. 2. Nurse and patient – Queensland. 3. Family nursing – Queensland. I. Hegney, Desley. II. University of Southern Queensland. Centre for Rural and Remote Area Health.

610.730692

Published by the Centre for Rural and Remote Area Health, University of Southern Queensland, Toowoomba, Queensland, Australia.

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EXECUTIVE SUMMARY

This project aimed to explore consumers' perceptions of the role of nurses in the general practice environment. The objectives of the project were to:

- Explore the expectations of consumers with regard to their perceptions of how a practice nurse (PN) expanded model of care would impact upon the care they received within general practice;
- Identify consumer's experiences with PNs;
- Ascertain consumer perceptions on the current role of the PN; and
- Ascertain consumer perceptions on the future role of practice nursing.

The project collected both qualitative and quantitative data from consumers living in southern and central Queensland in 2003. Data were collected by the use of questionnaires, focus groups, and semi-structured interviews. A total of 106 participants attended either the 17 focus groups or 10 interviews.

The Rural, Remote and Metropolitan Areas (RRMA) Classification 1991 Census Edition, was used to classify the geographical areas in the study. These were Roma (small rural and rural other); Toowoomba (large rural centre); Brisbane (metropolitan); Gold Coast (other metropolitan centre) and Longreach (remote). Recruitment of participants was through Divisions of General Practice, individual general practices, community groups and contacts within the communities.

All community members who were consumers of general practice care were eligible to participate in the study. The study included people who:

- Were both male and female;
- Were from both English, Indigenous, and English as second language backgrounds;
- Were from remote, rural and metropolitan areas;
- Accessed different types of general practice;
- Frequently, sometimes, and rarely visited their general practice; and
- Attended practices where Practice Nurses had been employed for at least 12 months;
- Attended practices where there were no PNs.

Of the 106 participants 82% were female and 58% were over 50 years of age. A larger proportion of older participants in the study were located in the Toowoomba, Brisbane and Gold coast regions. Participants were fairly evenly distributed across the five main locations. Of the total responses, 24% had young children, 35.6% had a chronic disease, 4.8% came from a non-English speaking background, and 20.2% were over 70 years of age.

The majority of general practices attended by these consumers consisted of between two and five GPs, with the bulk of these GPs being male. Participants indicated that they attended the GP mainly for prescription renewals and health assessments.

Most of the participants indicated that their GP employed a PN, and these PNs had been employed for more than 12 months. Whilst the majority of participants in this study had contact with a PN they did not know the PN's qualifications or level of registration. Additionally, they did not know the role a nurse (either registered or enrolled) could legally undertake. A recommendation of this study is that consumers be educated regarding the role of registered and enrolled nurses.

Once participants had been advised of the difference in scope of practice of registered and enrolled nurses, they did not believe that enrolled nurses should be employed as solo nurses in general practice. Further, they believed that newly graduated nurses do not have the necessary skills and knowledge for the PN role.

Consumers in this project stated that the PN should be recognised as an equal health professional to the GP. Demonstrations of this equality would be displayed within the general practice and would include the qualifications of GP/s and PN/s. Despite the fact that consumers believed that the PNs should be recognised as equals, consumers believed that the GP would only employ a nurse who had suitable qualifications for the role. Additionally, consumers trusted the GP to only assign nursing work to those who were qualified as nurses. Regardless of the models of PN used, consumers believed that PNs and GPs ought to operate as a team from a case management approach. The Indigenous consumers specifically mentioned that patients ought to be present when their case was discussed.

Consumers were comfortable with PNs undertaking roles that could be seen to be the traditional role of nurses in general practice. For example, they noted that wound management, vaccinations, monitoring vital signs, triage and phone advice were all tasks that nurses could satisfactorily provide. With regard to an expanded role for PNs, 70% of participants believed that a major role could be home safety checks and education related to health issues. Participants also believed that PNs could specialise in an area (such as women's health) as long as the nurses had the appropriate qualifications and clinical currency in this area.

The expanded role of the PN was viewed differently by different geographical and cultural groups. For example, participants in rural and remote areas believed that there were confidentiality issues in seeing a PN rather than a GP. They noted that in small communities, they would more likely socialise with the PN than the GP and therefore sensitive issues were better explored with the GP. Indigenous consumers highlighted the need for both GP and PN to deliver culturally sensitive health care. Further this cultural group noted that effective communication was crucial to therapeutic interpersonal relationships.

Whilst some participants identified triage as an appropriate PN role, via the phone or face-to-face, it is important to clarify that their use of this term was as a sorting process rather than use of the Australasian Triage Scale. This 'sorting' triage process would involve an initial assessment by the PN in order for the PN to make a decision as to the urgency of the consultation. Participants were not in favour if this triage role was used by PNs to 'gatekeep' within the general practice. Additionally, they believed that their choice to see a PN or a GP must not be eroded should a PN model of care be implemented in general practice.

With regard to notification of changes within the general practice, the participants believed that either personal letters or newsletters would be a preferred method of communication.

Participants articulated several positive outcomes from PNs working in an expanded role. From the GPs perspective, consumers believed that PNs could decrease GP

workload. Other benefits for the GP would be increased throughput in the practice, thus reducing waiting times for appointments. Advantages for consumers included perceptions that the GP would have more time to spend in patient consultations. Economic considerations of this changed workload were raised. These included that a Medicare item number should be available for PN consultations, but these should be at a lower rate than the GPs. The participants were most adamant that if they were to consult with the PN and the GP on the same day, that they would not be charged for two separate appointments.

The findings of this study confirm those of Cheek et.al. (2003). In particular,

- The working relationship between the GP and the PN and the united front they present to clients;
- That nurses act in a complementary role to that of the GP;
- That consumers must continue to be able to choose who they would see;
- The cost of seeing a nurse is only acceptable if they do not also see the GP at the same time;
- Consumers who have experienced a PN trust in the nurse's abilities;
- That an expanded PN role will increase accessibility to their GP; and
- Information about a nurse's qualifications, level of registration and therefore scope of practice is needed.

The new knowledge that this study adds to that of Cheek et al. (2002) is:

- There were differing expectations of the role of a PN based on geographical differences;
- That enrolled nurses should be supervised by registered nurses and that the enrolled nurse should not be the sole nurse in the practice;
- There was a role for nurses to undertake home visiting, particularly for a safety assessment of the patient's environment;
- That the PN can be generalist or specialists; and
- There were differences in perceptions of the PN role that were determined by the cultural need of consumers.

1.0 INTRODUCTION AND LITERATURE REVIEW

1.1. Introduction

The Australian Government has, over recent years, promoted the role of nurses in general practice through the provision of financial support to General Practitioners. For example, within the 2001-2002 Commonwealth budget \$104.3 million dollars was allocated to encourage more GPs to employ practice nurses (PNs). This funding, however, was only available to GPs located in rural and remote areas of Australia (Department of Health and Ageing 2002). In 2003, a further \$102 million was allocated for the employment of practice nurses and these places were not restricted to rural and remote areas. In the Medicare Plus package, there was also the generation of a Medical Benefit Scheme (MBS) item for practice nurse work involving immunisation and wound management. The introduction of a PN MBS item means that the GP no longer has to see the patient (Department of Health and Ageing 2003).

The concept of the role and function of the practice nurse in Australia was discussed at a national workshop in July 2001. Topics discussed at the workshop included: the qualifications required of PNs; codes of conduct; and legal and industrial relations considerations. These areas were perceived to be important considerations when employing a PN. The participants of the workshop believed that the PN role was complimentary to that of the general practitioner (DoHA 2002). Participants also noted that the role of the PN was developing and that role expansion could be used to increase the level of services offered from general practices. Areas that were considered suitable for PN work included:

- *providing clinical nursing services in the General Practice context;*
- *coordinating patient services;*
- *management of the clinical environment by assisting the General Practice to meet relevant standards and legislative requirements;*
- *health promotion and education by promoting patient, carer and community well-being;*
- *sustaining general practice by contributing to better management of human and material resources;*

- *improving health outcomes by contributing to and enhancing the management and prevention of ill health (DoHA 2002).*

In light of the increased focus on the role of practice nursing in Australia, the purpose of this study was to explore consumers' perceptions of the role of nurses in the general practice environment.

1.2. Literature Review

1.2.1. Practice nursing in Australia

In an address to graduate nurses at the Canberra Hospital in 1972, Dr Pang, a General Practitioner (GP), spoke about his concept of the practice nurse (PN). He described the PN as a member of the primary care team whose role was to contribute to the collection of data related to individuals or families with problems to enable an accurate and comprehensive profile to be constructed (Pang, 1973). He did not believe their role should be concerned with reception duties or confined to the carrying out of procedures. He stated that the PN should not be the doctor's assistant or handmaiden but rather a professional who acted in association with the doctor. Dr Pang's vision was to have patients enter the practice through the PN who would have her/his own room in which to conduct initial assessments before consulting the doctor. Although well before the Declaration of Alma-Ata, Pang's vision of the PN encompassed much of what Halfden Mahler (1985) later proposed should be nursing's role in primary health care (PHC): active partners in inter-professional and inter-sectoral teams and leaders and innovators in health care. He contended that nurses' roles would change as more moved from the hospital to the community and became resources to people rather than resources to doctors.

Similarly, the research publications of Jeanette Linn (also a GP) and colleagues over two decades demonstrate their beliefs that the PN should be a core and collaborative member of a PHC team. Linn (1969) became interested in the role of the nurse in general practice when, in 1967, she undertook a survey of the use of a health team in rural practice in South Australia. She found that the most important feature of the work of the PN was to co-ordinate the activities of the team, ensuring the continuity of hospital and domiciliary care for the patient. Other duties of the PN included

counselling for minor social problems, investigation of environmental factors affecting illness, health education aimed at prevention of disease, infant and child care, geriatric care, obstetric care, supervision of continuing physical and occupational rehabilitation programs, assistance with the organisation of multiple screening tests and participation in student attachment, practice research and educational programs.

In 1975, Linn went on to conduct a further study that examined the PN's role in managing, through domiciliary visits, chronic illness in the elderly (Linn, 1979). This study, which surveyed patients of more than 100 general practices in the suburbs of Adelaide, demonstrated that the nurse had a positive effect on the health, morbidity and lifestyle of this population. As a follow-up to the findings of this study, the role of the PN was studied in more detail in the early 1980s. Linn, Taylor and Oborn (1985) reported that, over a 13-month period, the PN made 427 visits to 80 patients, most of whom were over 60. The main purpose of the visits was to make additional assessments of physical, functional and emotional states in the home setting. The PN, also offered practical assistance in activities of daily living and undertook clinical procedures such as injections and wound dressings. Further studies were then carried out to evaluate the success of the PN's service to the chronically ill elderly (Linn, Taylor, Linn and Johnston, 1990). These studies reaffirmed the important contribution the PN made to early detection of medical and/or social deterioration and the prevention of further loss of independence.

Dunt, Temple-Smith and Johnson (1991) reported on a community nursing project, involving PNs, undertaken in Victoria in 1985. This project sought to describe the job characteristics of 689 randomly selected nurses working outside hospitals and nursing homes. Nurses who worked in private medical practices (both general and specialist) and those who worked in diagnostic and pathology services were classified as medical clinic nurses (MCNs). One hundred and thirty-two MCNs responded to the survey and they constituted the largest community nursing practice area. These nurses shared very few job activities with the other five large practice areas (community health centre, maternal and child health, community-based district and visiting, hospital-based district and visiting and occupational health). The most frequently performed activities, by the majority of MCNs, were reported to be technical care, interpretation of care requirements to patients, maintenance of patient

records, and liaison with other nurses. Only 49% provided health teaching, 33% counselling and less than 30% assessed individual health status or engaged in case sharing with other health professionals. By contrast more than 70% of each of the other categories of nurses frequently undertook health teaching, individual health status assessment and counselling. Apart from maternal and child health nurses, more than 50% of nurses in the other four categories of community nurses engaged in case sharing. The researchers concluded that MCNs' job activities were determined by the fact that they worked under the direction of doctors whereas the others did not.

In 1992-93 a study was undertaken of nurses in general practice in metropolitan Western Australia to gather relevant demographic data, identify their clinical and managerial tasks, and evaluate the effectiveness of their role, especially in relation to health education and health promotion (Le Sueur & Barnard, 1993). The researchers reported that, in some instances, their initial phone survey was met with hostility from doctors and/or practice managers who voiced concern that such a study was a means of replacing doctors with nurses. Ten practices indicated that their reception staff carried out nursing duties and one practice manager had stated that "[r]eceptionists can do any nursing jobs...doctors won't employ qualified staff because Medicare won't pay" (p. 93). Similar findings were reported in a later study conducted by Patterson, Del Mar and Najman (2000) in Queensland.

Le Sueur and Barnard (1993) found that the PNs' scope of practice varied enormously from practice to practice. Lack of funding, by way of either subsidy or medical benefits, was cited as a limiting factor to role expansion and autonomy. Telephone assessments were reportedly conducted by 89% of PN respondents but only 57% reported undertaking actual clinical assessments. When asked about health promotion activities, only 27% responded affirmatively. Sixty-seven percent of PNs claimed to undertake patient education, but this appeared to be part of their routine tasks rather than as a specific purpose of the consultation. Both GPs and PNs believed that the role of PNs could be extended to include health promotion, patient education, counselling and routine assessments.

A few years later another survey of general practices was undertaken, this time in Victoria. This survey attracted responses from 277 (61%) practices, many of which did not employ a nurse (Bonawit & Watson 1996). The demographic and occupational characteristics of the 93 nurse respondents were similar to those of the West Australian PNs surveyed by Le Sueur and Barnard (1993). The nurses were most commonly employed in practices that had three or more GPs and often had additional specialist doctors. Most respondents spent the majority of their time on clinical procedures, followed by receptionist activities. In addition they assisted with medical examinations and procedures, answered patients' questions about treatment and provided education about illness management and health promotion. Twenty-four percent made home visits to patients and 5% hospital visits.

Another Victorian study, utilised qualitative methods to investigate community-based nurses, including those situated in doctors' surgeries (Keyzer, Hall, Mahnken and Keyzer, 1996). Fourteen PNs were interviewed and ten PNs were observed in daily practice in their work area. All the nurses were RNs, the majority being hospital trained. The researchers described the PNs as being engaged in a broad range of activities including the care of pregnant women, parents with young children, the chronically ill, the aged and those with emergency conditions. Direct care activities encompassed health assessment, diagnostic testing, therapeutic treatments, client support, emotional care, triaging, health education and community liaison. A large component of their work involved assisting the GPs and other indirect care activities such as sterilising equipment and maintaining stock. Clerical and reception work took up only a small amount of their time. The nurse's ability to assess client needs, whether by phone or direct contact triaging was felt to be an important component of providing high quality care. Health education of a planned nature was not a formal function of the PN role essentially because the doctors' requests for procedures and assessments, phone consultations and managing the throughput of clients took precedence. Health screening was undertaken as part of an illness diagnosis rather than as a health promotion activity for well people.

In relation to their professional identity, it appeared to Keyzer et al. (1996) that the majority of the nurses viewed their role as primarily one of support to the doctors and secondarily as a service to the clients. Role boundaries seemed to be directed by the

doctor. Autonomy was limited as most of the clients were seen first by the GP and nursing activities were prescribed by the GP in order for a fee to be charged. Nursing contact with clients was primarily undertaken in order to support medical diagnoses and treatment of illness. This qualitative study supported the findings of the previously reported surveys.

Patterson, Del Mar and Najman (1999a) explored the demographic and occupational characteristics of a sample of nurses employed by general medical practitioners and the factors perceived to be influential in their role development in one General Practice Division in South-East Queensland. The demographic characteristics of this sample of Queensland PNs were very similar to those of the PNs studied in West Australia and Victoria. They tended to be mature aged with many years of both general and practice nursing experience. This sample of nurses spent most of their time undertaking traditional general nursing tasks with about half being frequently involved in ante natal care and assessment of infant development. Their activities were essentially determined by their medical employer and largely task oriented and assistive in nature. Autonomous initiatives appeared to be limited to health education and promotion activities, which were opportunistic in nature. Perceived barriers to role expansion included Medicare restrictions, inadequate basic and ongoing education programs, financial and space limitations of the practice, reluctance of general practitioners, and a lack of professional support. Other findings indicated that both general practitioners and practice nurses appreciated the value of nursing services in general practice and would sanction the employment of more nurses especially for the purpose of preventive care. The majority of nurses were agreeable to the notion that the nurse's role could, and should, be expanded to include autonomous functioning while most of the doctors were amenable to some extension of nursing practice but reticent or opposed to any independent interventions (Patterson, Del Mar & Najman, 1999b).

A qualitative study undertaken by Condon, Willis and Litt (2000) set out to explore the concept of 'shared care' between GPs and PNs in South Australia. They interviewed GPs and PNs in eight general practices across five divisions of general practice, a GP who did not employ a nurse and a GP and two nurse practitioners in a community health centre. The reported scope of practice of the PNs was very similar to that

found in other Australian studies and included essentially delegated clinical activities, triage, some education and health promotion activities and administrative/housekeeping tasks. The way the role was performed and perceived by PNs varied widely with some PNs describing a reactive approach to their work while others appeared to be more proactive. The authors concluded that these differences emerged out of largely tacit negotiations between GPs and PNs.

In the working relationship between GPs and PNs, shared care was not found except to some extent in the area of wound care. Condon, Willis and Litt (2000) concluded that most of the GPs in the study were satisfied with the PN's role and had little desire for change. The PNs could see little scope for change because they were already busy and satisfied with their role. The role of the PN was seen largely as improving the efficiency of the practice by increasing throughput and improving the effectiveness by allowing the GPs to use their time with patients more effectively.

A case study presented at an Australian national primary health care conference provides a different perspective on the role of a nurse in general practice. A Greek bilingual community psychiatric nurse was seconded to a general practice in Sydney as the result of a General Practice Grant. The practice serviced predominantly Greek speaking patients, and the nurse's brief was to develop a nursing role that would promote the health of a 'minority group' with multiple health problems (Anastasiou, 1993). The Ottawa Charter for Health Promotion was used as a model for reframing and developing services in this general practice. Initially in the project the nurse was expected to see all patients before the doctor to conduct baseline assessments and provide brief education on health issues identified from the assessment or the patient's file. However, because of problems with general screening and because the nurse's expertise was in mental health, general screening of all patients by the nurse was changed to consultation with patients referred by the doctor. An appropriate treatment plan was then devised jointly with the doctor. The nurse also ran a clinic for patients with asthma or diabetes. This nurse fostered a more health-promoting environment by organising linguistically and culturally relevant health material for use by patients and doctors. Thirty-one patients were surveyed about the nursing service. All patients expressed satisfaction with the nurse, however six preferred to see the doctor only; and 18 reported increased motivation with regard to diet, weight loss and

management of asthma and diabetes. The GPs and administrative staff were also surveyed. The most reported useful activities of the nurse were listed as providing health education to patients, resourcing the GPs with information on community services, and counselling.

Another study was undertaken by Teresa O'Connor (2002) in Queensland. This study had similar findings to that of the previously mentioned studies. For example, nurses in the study indicated they were 'undertaking a range of clinical nursing procedures, patient teaching and coordination activities' (p1.). A further finding of the study was that while nurses noted they did not feel confident in patient education, they did not request training in this area.

These studies indicate that, generally, Australian PNs are not functioning as Pang envisioned back in 1973 or as Halfden Mahler proposed in 1985. Common findings were that the PNs perceived their role as assistive in nature and practised accordingly. Their main functions were undertaking prescribed assessment and therapeutic activities. Health promotion and specific patient education were limited and not the primary reason for nursing intervention. Factors identified as limiting role development included a lack of funding, continuing education opportunities and special interest groups and the GPs' reluctance to relinquish any control. However, the case studies provided by Linn and colleagues (1969, 1979, 1985, 1990) and Anastasiou (1993) present a more positive picture of the PN role. In these cases, the PN made a significant contribution to the health of a particular population group (the elderly and a minority cultural group). It would appear that these nurses practised far more autonomously, and holistically in an environment that was supportive of teamwork. Although they undoubtedly acted as resources for the GPs the reports indicate that they were also significant resources to the patients and community.

1.2.2. Consumer perceptions of the role of practice nurses

Only one other study has sought to identify the consumers' perspective of the role of the nurse in general practice (Cheek et al. 2002). The study collected data from 20 focus groups distributed around Australia. Participants had varying levels of contact

with general practice and specific groups were held for people who were 'carers, elderly (75 years plus), or who identified that they had a chronic disease'.

The study (Cheek et al. 2002) found that generally consumers have a lack of awareness of the actual or potential scope of nursing in general practice. However, those consumers with a greater exposure to PNs, (such as carers and persons with a chronic illness) were able to suggest roles of PNs that extended beyond the traditional role previously identified in Australian surveys about PNs. Such expanded roles included development of care plans, providing education and support, prescribing continuing medications and undertaking Pap smears.

However, consumers also expressed concerns about expansion of the role. For example, they were concerned about:

- medico-legal problems for the doctor;
- possible substitution of doctors by PNs;
- nurses acting as gatekeepers and preventing the patient from seeing the doctor; and
- increased costs to the consumer for PN visits.

Overall, however, consumers were accepting of nurses in general practice because they trusted the GP to employ suitably qualified and competent nurses. They expected that GPs and PNs would work collaboratively and in the best interests of the consumer.

1.3. Conclusion

This section has introduced the study and provided an outline of previous Australian research into the role of the PN. The next section of this report will discuss the design of the study and methods used to collect and analyse data.

2.0 METHOD

2.1 Aim

The aim of this study was to explore consumers' perceptions of the role of nurses in the general practice environment.

2.2 Objectives

The objectives of the study were to:

- Explore the expectations of consumers with regard to their perceptions of how a PN expanded model of care would impact upon the care they received within general practice;
- Identify consumer's experiences with PNs;
- Ascertain consumer perceptions on what is the current role of PNs;
- Ascertain consumer perceptions on the future role of PNs.

2.3 The Study

The study comprised multiple methods of data collection including:

- A questionnaire;
- Focus group interviews and/or;
- Individual interviews

2.3.1. Classification of areas

In order to ensure that people from varying areas were represented in the sample participants were included in the study from five different areas as classified by the Rural, Remote and Metropolitan Areas Classification 1991 Census Edition (Department of Primary Industries and Energy and Department of Health and Human Services 1994). This classification has been used to classify the geographical localities of the participants in this study. These are:

- Other remote area - uc pop < 5 000
- Remote centre - uc pop = 5 000
- Large rural centre – uc pop 25 000 – 99 999
- Small Rural centre – uc pop 10 000 - 24999
- Other rural area – uc pop < 5000
- Capital City (Brisbane)

- Other metropolitan centre – uc pop = 100 000

2.3.2 Participants

All community members who are consumers of general practice care were eligible to participate in the study. The study aimed to include people who:

- Were of both male and female gender;
- Were from both English, Indigenous, and English as second language backgrounds;
- Were from rural, regional, and metropolitan areas;
- Accessed different types of general practice;
- Frequently, sometimes, and rarely visited general practice; and
- Attended practices where Practice Nurses had been employed for at least 12 months;
- Attended practices where there were no PNs.

To ensure that people who were most likely to access general practice were included, the following groups were targeted:

- Parents or carers of young children;
- People with a chronic disease; and
- The elderly (defined as people over 70 years of age).

Recruitment was initially commenced through individual general practices or through a Division of General Practice. After identifying potential participants from the groups mentioned above, the practice or Division distributed brochures detailing the purpose and extent of the study, together with consent forms. The rural and outer metropolitan areas were the areas where a majority of participants were recruited using this method. In the other geographical areas there was minimum to nil input from general practice or divisions. In these cases, the majority of participants were recruited through community groups and contacts from within the community.

The target groups were all included in the study ensuring that a broad range of the community was represented. This increased the transferability of the findings of this study to the broader community.

In some cases, people who had indicated they would attend focus groups, did not turn up on the appointed day and time. As a result, in some cases the participants in the focus groups were smaller than would normally be expected. For the purpose of this study, it was decided that if more than two people attended a group, it was called a focus group. Interviews involved one or two participants.

A total of 17 focus groups and 10 interviews were held over the five geographical localities. Of these 12 people were indigenous.

2.3.3 Data collection

a) Questionnaire

The written questionnaire comprised items to elicit demographic data (such as, gender, age, geographic location,), practice data (such as number and gender of doctors and practice nurses), reasons for attending a GP, and level of comfort with potential practice nurse activities. These items on the questionnaire were identified from the literature review, the Department of Health and Ageing fact sheets and from practice nurse models in the UK.

The questionnaire was reviewed by three nurses, one general practitioner and four consumers prior to its use. Changes suggested were incorporated into the questionnaire.

Questionnaires were given to participants before each focus group or interview, following an explanation of the reason for this data collection method. The research team provided clarification of any items if requested but ensured the privacy of each participant when they were completing the questionnaire.

b) Focus Groups

Focus groups were deemed the most appropriate method of collecting data as at the time of the design of the study, there had been no previous Australian research into consumer perceptions of the role of the PN. This method was chosen as it allows the

participants to lead the direction of the research. Focus groups also create a synergistic environment where participants are energised to build on ideas and input from other participants allowing the topic to be explored in-depth.

Two members of the research team facilitated the groups ensuring that groups maintained focus on the topic. A set of questions and prompts were developed for the study to ensure all areas of interest were covered (see Appendix 3 and 4). The questions were only used as a guide and the group explored the areas as they occurred in the discussion. It was ensured that quieter members of the group were enabled to express their views, and that no one person dominated the group to the exclusion of others.

c) Individual Interviews

Interviews were held in order to gain opinion from people who did not want to be part of a focus group; could not attend a planned focus group; or did not have sufficient time to attend the focus group (focus groups normally were held over a two hour period and interviews over a one hour period). In most cases interviews were held in the participants' home. The same questions used in the focus groups were also used at interview – again with the questions being only used as a guide to ensure all topics were covered. Like the focus groups, interviews followed their natural course to allow the participant and researcher to explore ideas as they arose.

2.3.4 Data analysis

a) Quantitative Data Analysis

Analyses conducted on the sample data (n=106) were performed through the Statistical Package for Social Scientists (SPSS) program, version 11.5.

Data Screening

Prior to analysis, data screening was conducted on all of the variables. The data were examined for accuracy of data entry, missing values, and fit between their distributions and the assumptions of multivariate analysis. Case Nos. 13, 35, 79, 9, 38, 82 and 77 did not complete a large proportion of the questionnaire, therefore these cases were dropped from further analysis.

Assumptions for Factor Analysis and Analysis of Variance

A number of missing values were replaced using the expectation-maximisation (EM) algorithm (Roth, 1994) in SPSS version 11.5. It was noted that these cases were primarily from the over 50 age group. Six cases were identified as multivariate outliers (Case Nos. 1, 5, 19, 25, 42, 97). These outliers were checked and identified as properly part of the target population (Tabachnick & Fidell, 1996). To assess whether these outliers would impact on the solution, analyses were run with and without the outliers. The final solutions showed that the amount of variance explained did not appreciably improve. As a result, the outliers were retained in the dataset.

The skewness and kurtosis of the items were examined to assess normality. Several of the items had moderate to large skewness and kurtosis. A variety of options were explored to improve the normality of these variables, including square root transformation of the data. As none of the options appreciably improved the data, no transformations were conducted. Patterns of skewness in the variables suggested a violation of the assumption of linearity. Given that it was impractical to examine all pairwise combinations of variables, scatterplots were conducted on pairs of strongly skewed items. An examination of these plots indicated that linearity of the variables could be assumed. Examination of Levene's test of Homogeneity of Variance indicated that homogeneity of variance could not be assumed. To reduce the chance of the tests overestimating the differences as a result of the variances not being homogeneous, a more stringent level of significance was applied.

b) Qualitative analysis

The qualitative data obtained from focus groups and interviews was firstly transcribed verbatim; the transcripts were then checked for accuracy. The data were then divided into groups according to geographical location and analysed separately. The Indigenous group data were also analysed separately.

The data were then analysed to identify themes, patterns and possible meanings. This was carried out independently by two researchers who then met and compared their findings to enhance the rigour of analysis. Themes were then refined further and

the meanings beneath the themes and the differences between the groups discussed and documented.

2.3.5 *Limitations of the study*

As participants were recruited through contacts, the study therefore had a convenient sample of participants. This type of sampling may mean that only a particular group of people who belong to community groups or who have the time to attend focus groups and interview participate in the study. As many of the findings of this study concur with the Cheek et al (2002a) study there is some confidence to suggest that the findings do reflect consumer perceptions of practice nursing beyond the scope of this study.

2.3.6 *Ethics approval*

Ethics approval for this study was obtained from the University of Southern Queensland's Human Research and Ethics Committee. A plain language statement and consent form was developed in brochure format. The brochure described the study and provided contact details for the research team at USQ. This was given to potential participants who were asked to return them to their general practice, post them to USQ or bring them with them to the focus group/interview. Prior to commencement of the focus group or interview participants were again given information about the study and advised they could leave or withdraw their information at any time. They were also requested to keep what was said in the focus group as confidential.

2.4 Conclusion

This section has described how participants were recruited into the study; the methods of data collection for this study; data analysis; and the limitations of the study. The study was approved by the USQ Human Research and Ethics Committee. The next section will discuss the qualitative results of the study.

3.0 QUALITATIVE RESULTS

This section outlines the qualitative results of the study under the major themes: choosing and accepting PNs; the scope of practice of the PN; factors influencing consumer choice of a general practice; characteristics of successful general practices; collaborative relationships – based on communication between GPs, PNs and patients; and payment of PNs and GPs. The quantitative results of the study will be discussed in Section 4.

3.1. Choosing and accepting practice nurses

There were several aspects to the theme of choosing and accepting PNs which included: qualifications; skills and experience; delegating the role definite of PNs to GPs; characteristics of PNs; identifying the PN and acceptance of the role of the PN.

3.1.1. Qualifications, skills and experience

In general, participants expected that the PN would be a registered nurse (RN). In a smaller practice participants believed that a PN position was too isolated from professional support, therefore they believed that enrolled nurses (ENs) would not be appropriate. In a larger practice participants believed that the Enrolled Nurse would be able to undertake some duties as long as this was within the scope of practice of the EN. As one participant commented:

This is just like I was saying, I think they should all be registered nurses, I'm sure there are big clinics where they have enrolled nurses as well that have certain duties, I'm just used to the clinics I've always gone to. It's been the registered nurses to assist the doctor you've gone... [to see] for whatever. They've prepared you for when doctor came in and I just, I take it for granted, I expect it actually.

Experience was considered an essential characteristic of a PN. Participants believed that if a nurse had worked in a hospital and had experience in a variety of areas they would be able to have the knowledge to care for a variety of people in general practice. Thus experience was seen as an essential component for participants to be confident in the abilities of the nurse. As two participants stated:

... if it is a small surgery, they've only got the doctor there...they've got to have, I'd say at least five years experience in a hospital, and very diversified. I think if possible, even down to having done some time in an aged care centre, so that they can go from bub to elderly. If not, if they employed say two or three nurses in the centre, each one should have their own sort of speciality.

I wouldn't want to give my medical trust to someone who's just finished their four years, I would probably still want to see the doctor, but if they finish four, or how ever many years of nursing, and they've got some experience then you gain that mutual respect and that trust back.

In those cases where specialist knowledge was required (for example, asthma, diabetes), the participants in this study believed that a generalist PN would be required to undertake additional training. However, regardless of the level of speciality of the PN, participants expected that the PN would continually update their skills and knowledge. In-services were seen as the best way to gain information and participants expected that the PN should be supported by the GP to attend. Tertiary courses were seen as an advantage but not essential. Two people remarked:

Ongoing for whatever is happening in that specialty area that they're working [in]. Things are changing all the time.

I mean I'm one of those people that, I sort of expect that people do more than the minimum, I would, yeah I'd like to see people actually learning more new things all the time, not just have that piece of paper and that's it for the next twenty-five years - that scares me a bit.

The participants believed that the PN needed to display evidence of competence in what they were doing. If the PN appeared confident in the procedure they were undertaking participants believed that they would be more confident in accepting their care. Participants felt they could identify the PN's abilities by the confidence they displayed whilst attending to patients. Regardless of the qualifications, skills,

knowledge and experience of the PN, the participants stated they would be confident in the PN because the general practitioner (GP) had verified the nurse's competence before employing them.

3.1.2. Defining the role of the practice nurse.

There were no obvious differences between different regions or cultural groups with regard to this theme. Generally participants stated that if they trusted their GP they would trust the PN the GP employed. They believed that the GP would ensure that the PN was qualified to work in the roles indicated by the individual practice. As one participant noted:

And like if I trust him I say, "well [nurses name] will be able to do it", "oh yes she'll be able to handle that for you". Well I've got sufficient trust in the doctor to believe in her.

The participants also stated that it was the GP, rather than the PN, who was the best person to decide the role of the nurse within the practice. Again, this would be decided on the skills, knowledge and experience of the PN. However, ultimately it was the consumer who would decide if they would see the PN or the GP. These participants stated that at times they would want to see the GP rather than the PN, even if they were normally comfortable with the PN. They did not want the PN to be a barrier to them accessing their GP. As one participant elaborated:

Even if you've got a choice, if you can go ... to your local practice and say, "I want to see the nurse to start with", and then if you want more, you know before something or then the doctor gives you the choice well you know you've got to come back several times, do you want to see me or the nurse, if we're always given that sort of option and there is that flexibility within the practice, that to me seems the best of both worlds.

Participants also stated that if they or others they have spoken to, had good experiences with the PN, they would be more likely to be comfortable to accept care from the PN. As one participant stated:

... both of them don't get flustered, they don't panic, they can handle the patients with ease and as I said the majority of the time they know. Now it's all experience you know and I look at these, particularly these two women and I'd trust them with my life, they could do any, these particular two they could do breast examinations, they could do pap smears, they could do whatever they liked to me because I trust them implicitly, both of them.

3.1.3. Characteristics of the practice nurse

It was considered essential that the PN have good interpersonal skills. These skills would be used when the PN first met a new client and then would be used to build a relationship with the patient and provide personalised care over time. The participants believed that if the PN was able to make them feel comfortable they would verbalise more to the PN and be happier to accept the PN's care. They also perceived they could have a more personalised relationship with the PN. This personalised relationship would lead to the PN gaining a better understanding of their health care needs and the factors affecting those needs. As one participant stated:

Initially I think her [sic] ability to communicate when she first met you. Before she does anything else 'cause unless you feel happy and at ease when someone's going to be working on you [you] sort of tense up, you're not as relaxed. So I think initially the communication. Whatever communication takes place within that first couple of minutes.

3.1.4 Identifying the practice nurse

Many participants indicated that it was difficult to distinguish the PN from other staff at the practice. This concerned them, as they believed they were not informed who was providing their care. They noted they would be more comfortable knowing that it was a nurse caring for them, rather than trusting their care to someone who was not qualified as a nurse. Participants indicated that PNs could be identifiable by wearing name badges and having different uniforms from other staff. As two people commented:

There's a receptionist there, then somebody wanders in there and I mean in reality you've got no idea who to see. No, well, I wouldn't know what qualifications the girls down there have got, I really don't.

People feel a bit more uncomfortable about asking though too. It's like as if you're saying, "maybe you're not qualified to give me this injection". They don't want to be insulting you, but it's just that nice little bit of confidence for you just to say, "yeah she is trained, it's not the receptionist come through to do it for me".

3.1.5. Acceptance of the role of the practice nurse

Participants stated they would like to be informed of any changes occurring in the general practice they attended. They believed that if they were more informed about the PN and their qualifications that they would have more confidence in accepting the nurses' care. They also thought that this information would enable people to have a better understanding of what the PN's role is in the practice. It was thought that changes could be communicated to patients through a regular or at least an introductory newsletter. One participant explained:

Maybe something in the surgery, a newsletter or some such thing and saying that we have available Sister Mary Smith and she has undertaken such and such. See I'm a person who likes to see all this sort of thing. She has undergone such and such training and she has a special interest in asthma or whatever and explaining a little bit about that person so it's not just, "oh Mary she can look after your ECG", or whatever. I would like to have that in writing, I would read that. I know a lot of people don't bother. I read everything like that and I would think, "well this person obviously knows what she is doing", that would inspire more confidence. I mean I would trust my doctor if she said that this lady is competent to do this or whatever but to me that would be one thing, a constructive thing that would show people that that is what they are here for and what they are capable of doing.

3.2. The Scope of Practice of the practice nurse

3.2.1. What is the role of registered and enrolled nurses?

In general the participants in this study did not know what the role of the nurse was. They stated that they were able to identify the roles of other health professionals such as physiotherapists. However, they were unable to explain what the nurse's role was in association with these other health professionals. The majority of the participants were also unaware of the differences between an Enrolled Nurse and a Registered Nurse. This lack of understanding and knowledge regarding the different levels and roles of the nurse, lead to a confusion and uncertainty about what ought to be the scope of practice for PNs. Many participants also believed that the role needed to be identified and promoted in the community to allow people to be informed. As two participants stated:

But I just think that nurses have not established a position. There was the day when the nurse gave you a massage and the nurse did this and the nurse did that, most of those jobs are taken over by specialists. You now get the physiotherapist in to handle it.

I don't know the difference. What's the difference between an enrolled and registered nurse?

Participants in the study also believed that university training has clouded consumers' understanding of the nurse's role as, unlike hospital training, many are unaware of what training occurs in a university as it is invisible to them. They are concerned this change has made the role of the nurse more technical and less caring. As two participants noted:

Nurses now go to the university and do a completely technical course at the university as well as their practice, what is their role? I think at the moment the nursing profession is struggling to find their role.

It became blatantly obvious to me that from the university approach nurses didn't know what they were, they were sort of somewhere between a doctor and the cleaner, but just where, they were struggling to find out.

The commonality of thought amongst participants was that PNs could and ought to perform high-level skills as long as they were qualified, trained and experienced in that area. This acceptance was qualified however, as many participants expressed concerns that PNs would undertake what they considered to be the role of the GP - for example, diagnosis and prescribing. In contrast, some participants welcomed the ability of the PN to be able to diagnose and prescribe as they believed that accessing health care would be simplified if both the GP and the PN could provide these services. As two participants explained:

I certainly think nurses have the expertise and they should have more reason to give their skills.

I think prescriptions and actual diagnosis, they have to be left to the doctor...but I think follow-up...can be done adequately by experienced nursing staff.

When asked, participants indicated they would be comfortable with the PN managing the care of their chronic illness as long as it was done in consultation with their GP. As one participant stated:

I would be quite happy in terms of management of chronic illness to see the practice nurse.

3.2.2 What tasks can a practice nurse undertake?

The participants held opposing views on the issues of PNs undertaking pap-smears, with some participants believing that this could be a role for the PN. Others believed that this could only be undertaken by the GP, as the GP would notice any other abnormalities whilst completing the test, which might be missed by a PN. Many participants stated they would prefer a female for women's health issues such as this. It should be noted that the participants in this study saw GPs as male and PNs as female. Participants stated they would have to be assured of the nurse's training and experience before agreeing to see them for a pap smear. As one participant stated:

They will go to a female doctor just for their pap smears, but they go to a male doctor for most of their other things... I wouldn't be opposed to seeing a nurse for things like that. I mean obviously they would be trained to do it and ...[they would] probably be more sympathetic.

Participants exhibited mixed feelings regarding the ability of the PN to triage. Many participants stated that often they may have some illness and that in these cases they would not consider the problem serious enough to consult the GP. In these cases, the participants believed that a consultation with a PN would be useful. Additionally, the majority of participants believed that a PN who triaged all calls into the surgery would benefit both the GP and the consumer. As one participant commented:

I think that if you use nurses to sort of like do a triage when people come in and the ones that were really sick could go and see the doctor and those who could be reassured with just plain common sense and nursing care. It would help the whole medical system.

However, some participants saw a PN who undertook triage as a 'gatekeeper' and were concerned that the PN's triage role would be used as a barrier between the consumer and the GP, decreasing patient accessibility. As one participant states:

Well if you had, if the patient had freedom of choice, but I mean would some doctors say, "right now all my patients with minor blah, blah, blah you will be seeing this nurse", could they you know enforce that? Enforce it, take away the patient's right to see a doctor?

The majority of the participants stated they were more comfortable discussing many issues with a nurse rather than a GP as nurses generally, are seen as more approachable. Nurses were identified by the participants in this study as taking a more holistic approach to health care as nurses looked at the person's whole picture including environmental issues, therefore gaining a greater understanding of the patient. Participants believed that the PN and the GP working as a collaborative team

ensured that the practice provided a higher quality of care to patients. As one participant explained:

Doctors are very medical minded and look at the, you know, the narrow picture I guess but it's sometimes, a lot of the times you see a nurse and they look at the broader family. ... So ... a doctor might just look at your ... blood pressure and the sound of a heart or the sound of the lungs or whatever but a nurse looks at it from the whole family perspective and how you're dealing with things. Just lifestyle things that make sometimes make coping easier. Not necessarily in a medical way, but just in a whole broad perspective and then if you're in a better frame of mind, obviously things then progress ... [so] you're better too So sometimes the nurse has a lot more, I don't know a wider picture, a wider focus rather than just medical.

The participants indicated that if the PN took an extended role in the practice, this would take some of the workload off the GP. They believed that this would result in an increase in free time for the GP, possibly helping to decrease the GP's stress. They also noted that if the GP had more time they would be able to have longer consultations if necessary, thus increasing the quality of patient care. Participants also believed the increase in GP time could reduce the time they waited in the surgery for an appointment. As one participant stated:

So the actual quality of the service is probably better than the quantity. So you go there and you're getting really good quality for your time, then you know you're spending half the time there, but you're getting more information and service.

3.2.3. Consumers' experiences of practice nurses and their role within the general practice

Those participants who had experienced contact with PNs generally held them in very high esteem and stated they were happy to see the PN when appropriate. The usual contact with the PN was either being referred by the GP to the PN, or when the PN worked in a triage role within the practice. As one participant stated:

And she also does ...[the] accidents that come in and the dressings and ..., plus all the ECGs and like I was saying with asthma you know when I go over it's [name of nurse] that I go in and that puts me on the nebulizer, you know does the reading and puts me on the nebulizer with the oxygen till you're, till you're recovered from it and then the doctor comes in.

The most common procedures mentioned by the participants in the focus groups that PN's were currently undertaking included:

- Dressings;
- Blood pressure;
- Immunisations/injections;
- Triage;
- Phone advice;
- Removal of sutures;
- Assisting the GP; and
- Blood tests

Additionally, participants noted that PNs were involved with chronic disease management. In these cases, the PN was responsible for follow-up and undertaking regular testing such as taking ECG's and measuring lung function using Spirometry. The nurse provided education to the patient about their chronic disease. The participants who had been exposed to these activities of the PN indicated they were very comfortable with the nurse being involved in this area of their care. As one participant stated:

The practice I go to they do all the asthma checks and spirometry and they do all that before the doctor actually comes and sees me.

Many participants mentioned that the PN had supported them emotionally. Sometimes this emotional support was provided during a routine visit, other times during a personal crisis. The provision of emotional support to patients by the PN, was seen as a part of the PN's role, and was highly valued by the participants in this study. One participant described this situation:

I mean I was pretty wound up, my husband was really on edge and she was really wonderful, she really calmed us down, and made us relax and really handled things rather well and I felt she was good in that situation.

3.2.4. The future role of practice nurses

The findings of this sub-theme are reported by geographical locality as the participants in different geographical areas had differing perceptions of the future role of a PN.

a) Remote Areas

Remote area participants were the most ambiguous of all participants in their beliefs. They could see many advantages in PNs taking on an advanced role. They saw that it could make up for the areas they perceive as lacking in the current service, such as access to health care and their ability to build a relationship with their GP. They saw that the PN could increase access to the GP, but also the PN could build a relationship with the individual. Thus the PN would be familiar with the patient's health needs, and provide them with continuity of care. As one person comments:

It's more the relationship because you establish a relationship like you say you know the doctors come and go here, if you had an established relationship with a practice nurse who you trusted you'd probably rather see her than a new doctor.

These groups could see some barriers to PN's increasing their role. In particular, where would the nurses would be obtained for new positions in general practice. The major concern, however, was they did not believe that nurses had the qualifications to make decisions. Rather, all care decisions should be the responsibility of the GP. Several extracts from the transcription of one focus group explains this more:

Maybe they do the things where they don't have to make a decision like vaccinations, pap smears.

Where there's no choice.

Treatment of wounds like surely you'd know if a wound's infected or not and you could pass it on to a doctor.

Yeah.

But like if a nurse can do pap smears, that's not up to them because that gets sent away, they've got to just do it.

Anything where there's maybe no decision that needs to be made

Privacy was also an issue as participants noted that they are more likely to have social contact with the PN than with the GP. They felt that the practice nurse was more on the patient's social level. This was an advantage as it made them more approachable, but also a disadvantage as it could be uncomfortable with sensitive issues. As one participant noted:

I think sometimes nurses are seen more, I don't know on the social level as members of the community whereas doctor are sort of seen on that high level so it's okay to go and have a pap smear with a doctor because he's up there, but if the nurse did it, you still, you're more likely to bump into the nurse in a supermarket.

b) *Rural*

Rural participants saw the largest advantage of the PN role would be triage and diagnosis and treatment of some minor illnesses. The participants perceived that the triage role would direct patients to the source of appropriate treatment. The triage role would also expedite patients' access to services and relieve some of the work pressure from the GP's. As one participant explained:

Well, a nurse ... [is] the first port of call ...I suppose it is that triage sort of thing, but yeah...I can certainly see a role for a practice nurse being much more comprehensive one than it is now.

c) *Regional*

The participants in these focus groups expressed the desire to see the traditional skill base of the PN expanded to complement the GP service. They expressed a need for the nurse to visit the person's home, as they believed this would regain some of what has been lost of the GP's role. They stated that the quality of patient care would benefit from the nurse's holistic approach. Another benefit of the PN role was that the GP would have more time, either to spend with patients or for more recreation for themselves. As one participant stated:

I think if she [sic] can do so many more things then this relieves the pressure on the doctor and maybe our doctors will be able to get back to this, "oh good day Fred, how are you", and start off with a little chat which relaxes the patient and they get back to what the old, the old system used to be like. Where you didn't go in and out in two minutes, you had that five to ten minutes per patient you know with the doctor time.

d) *Metropolitan*

Metropolitan focus group and interview participants believed the GP and the PN had both specific and different roles. They stated the GP and the PN had different skills to offer and should work as a team to meet people's health needs. As one participant stated:

They need to complement each other, that's the word, they need to complement not, yeah they're not taking over, they're just complementing you know. The doctor has certain skills that the nurse can't, doesn't have and vice versa. And that's how you should have a team but they all can't be the same or else it means that maybe you can't meet a particular population's health problems and they have to go somewhere else.

e) *Outer Metropolitan*

All participants from this area preferred the role of the PN to be expanded and be collaborative with the GP. They saw that by increasing the scope of practice of the PN patients would receive more personalised and convenient care. As one participant commented:

Somebody who could spend more time with you and take the pressure off the doctors if you feel like you're in there rushing all the time and you've got to rush out again, so I see them taking the pressure off and being the educators.

They also commented that the care they received would be of higher quality and cost them less time. Similar to the rural and regional participants, they believed that the introduction of a PN would allow the GP to reduce the hours they have to work. For example:

So the actual quality of the service is probably better than the quantity. So you go there and you're getting really good quality for your time, then you know you're spending half the time there, but you're getting more information and service.

They also expressed a concern for the lack of services for older persons and stated that the PN role would be of benefit in this area. They thought that the PN would be able to have both an education and assessment role and also be able to access services already in place in the community. As two participants comment:

So maybe they just need someone to keep reassuring them that they're going in the right direction?

[They] can take the time to talk to them and you know, "let's work out your medication", and you know, "this is something you can do".

f) *Indigenous*

Indigenous participants identified that the GP and PN roles were separate. They indicated that both the GP and the PN had skills to contribute to the health care of patients. The GP's role was seen as diagnosing, treating and prescribing whereas the nurses' role was seen as being more the ongoing management of the client. Notably they did not want these roles to be blurred.

It mustn't take the doctor's role from the nurse role and vice versa. So a qualified doctor is a doctor treating you.

The roles they described were what many Indigenous people are already familiar with in Aboriginal Medical Services. The participants in the Indigenous focus groups were pleased for nurses to expand their role as long as they had appropriate education and experience, and quality of care was maintained. They believed that the expansion of the role would benefit them in accessing services and would also improve access to health care. Some comments were:

I think all these the practices you've got written down here that the nurse, the practice nurse could do would be really great actually...There's some that I wouldn't be, you know I'm not real sure about but that depends on what you know, to what qualification they've got. I mean...there's some things that I wouldn't, wouldn't ever feel comfortable with, ... not that I devalue a nurse, nurse's opinion, but sometimes it's the doctor who you want to hear that from.

3.3 Factors influencing consumer choice of a general practice

This theme, whilst not discussing consumers' perceptions of PNs, informs the study of the characteristics of a general practice which would encourage a consumer to use that general practice, for example, bulk-billing and location of practice.

3.3.1. Referral from others

When choosing a practice the participants stated they would confer with others and take into account other people's opinions of the practice. The participants stated they would usually choose a GP on a recommendation from another person. They would, however, only continue with that GP if they were comfortable with them. As one person states:

I like to know something about the doctor so I would like to ask people what doctor they'd been to and know a little bit of their background before I go to a doctor and then I feel more comfortable. I don't exactly like to take them at face value just because they're a doctor.

3.3.2. Bulk-billing

For others bulk-billing was the most important consideration when choosing a GP. Many participants stated they had chosen a GP solely because the GP bulk-billed, and therefore would have to accept whatever quality of care they provide. As one participant stated:

Very first does he bulk-bill?

3.3.3. Location of practice

The proximity of the practice to where a person lived was also a reason given by the participants for choosing a practice. This was especially important when the consumer relied on public transport. This sub-theme was evident in the participants who lived in a metropolitan area. As one participant explained:

I think location, as I said before is ... something that's... important to me. It's only [in] the last year that I've actually had a car, so all the doctors I actually have gone to have been very close. Thing is, when you're quite ill, the last thing you want to do is drive...

Many of the participants also provided further details about factors within the practice environment that would make them choose one particular practice over another.

3.4. Characteristics of practice environments attractive to consumers

Participants in the study mainly focused on the interpersonal skills and comfort factors associated with general practice, hence these factors are reported on in-depth.

3.4.1. Interpersonal skills

The main focus of participants in all the different focus groups was the interpersonal skills of the GP and the other practice staff. Participants believed that the GP was most likely to gain a better understanding of the consumer's health issues if they spent time with the patient, listened and respected the input of the patient. Although interpersonal skills were identified as important in all groups there were variances in

the types of interpersonal skills that participants in different areas perceived to be important.

a) *Listening*

Participants in all areas indicated that the GP needed to listen to their concerns. They stated that this made them more comfortable with the GP and allowed the GP to obtain a better insight into their health issues. Further, the participants in the rural focus groups believed that a GP should value the patient's input and experience, and listen to the patient in order to form a diagnosis. These participants thought that they should have an active part in their care planning. Further, when the GP listened and took notice of patient needs the patient would attain better health care. As some participants explained:

Someone you can talk to, someone who listens to you

I started being more, I felt more in control about what I felt should happen and as the years have gone on I feel that I have a right to say what I feel is best for me in consultation with my doctor and perhaps the practice nurse.

If they listen to you then you've got a better chance of getting the care and the quality of care that you're looking for.

b) *Time with GP*

Many participants in the focus groups stated they needed to feel that the GP had time to spend with them. They did not like feeling that the GP was rushed and that they needed to be as quick as possible with their complaint in order not to waste the GP's time. Again they believed that sufficient time with the GP would allow for a better assessment of their needs. As one person commented:

Well a kind doctor...that will sit and listen to you and feel that you've got plenty of time because some of them, I do feel, not so much here but that they just rush

you through and I think that that would be one of the most important things and caring and go into detail, not just fob you off like some of them may do.

c) *Caring*

The need for the GP to care about the patient was mentioned by most of the participants in the rural and metropolitan focus groups. Participants believed that GPs needed to focus on the social needs of the patient, such as their ability to pay for the visit or the services needed, as much as they focused on the physical needs of the patient. As two participants stated:

He bought extra equipment to help us. So he really went out of his way to help us. Like thousands of dollars worth of equipment just to help us.

There was no, yeah I wasn't treated any differently because I owed them the money you know, I wasn't made to wait or fobbed off or anything. They realised not everybody is as fortunate as some people can be, but then they still got to provide the service to you, you know, despite the fact that you may owe them for a while, but they know you'll come good eventually. They won't see you, they wouldn't refuse me if I owed them money, they wouldn't tell me to go somewhere else.

d) *Acceptance*

The participants who participated in the mental health focus group also thought it was important that the GP accept them and take them seriously. They stated that at times they were not taken seriously and that the staff in general practices did not listen to their needs, as two participants explained:

... I like to see somebody who will take me seriously, listen to me as a person. They accept you for who you are and the person that relates to you and it doesn't matter what condition you're in they'll accept you anyway and they'll want to know more about you instead of pushing you away kind of thing. But you know someone who will listen and take care of you and knows where you come from.

The first contact point, like you mentioned in your survey, I believe that strongly should be the first because talking to a receptionist is often quite infuriating because you're in need of treatment obviously and you're in need of attention and in no way am I criticising the medical profession but I just say that there can be a lot done towards actually you know maybe even a diagnosing the need to come and see the GP.

e) *GP approachability*

It was considered important by the participants in this study that the GP was friendly and approachable. Participants thought this would make them more comfortable and at ease with the GP and make them feel as though they could talk to the GP. As one participant stated:

Even I would kind of keep going into a surgery until I could actually find someone that I could feel comfortable with... cause that's very important to find someone that understands you, is prepared to listen and may be good with you.

3.4.2. Continuity of care

The participants in the focus groups held in remote areas, all expressed concern that they were not able to have continuity of care with the one GP as GPs did not stay in the remote areas for a long time. They perceived that the high turnover of GPs impacted on the quality of care they received. As one participant commented:

If you go and there is a problem...say if you come back in a week, it's a different doctor. [However, if] you can go back to that same doctor, you've got that continuity and the follow up. And you don't have to explain to them when you go in you know you don't have to explain to them why, what's wrong with you 'cause they know what's wrong with you hopefully.

In contrast, the participants in the rural focus groups valued the continuity of care they believed they received from their GP. They stated that they needed to know the GP and be known by not only the GP but the PN and the reception staff. This allowed the consumer to have a more personalised service. It also allowed the GP or

the PN to have a greater insight into their health needs. Some participants elaborated:

Someone who knows your circumstances, your family history and your problems. You don't have to go to a stranger at any time you have the same person.

Well you know their kids or you end up teaching them or they're in musicals or play sport with a lot of the staff you have a lot of social interaction – at different levels – with the people who are looking after you. So they're asking questions, how's so and so's head or hand or foot or whatever it is..... They do care though, they do care about you personally I feel. Well the one's I'm involved with do.

You know your GP is a constant factor in your life. Whereas if you come, ... to the hospital you never know who you are going to see or who is going to be here. Whereas the GP is the constant and that is the person that you can trust.

3.4.3. Accessibility of appointments

The participants in the remote area focus groups were also concerned that because of inaccessibility of appointments, when they needed treatment for an acute illness, they had to take appointments with the GP who had the closest available appointment. This impacted on them being able to build a relationship with a particular GP. As one participant stated:

If you can plan ahead for something that you want to particularly see your own doctor for you ... ring up the week before, it's a bit hard when you're sick though.

3.4.4. General Practitioners continued education

The ability for GPs to remain up-to-date through accessing continuing professional education was a concern expressed by participants who attended the focus groups held in remote areas. The participants attributed the lack of access to continuing professional education to the GP being unable to leave the practice due to their high workload. They also perceived that the GP's knowledge suffered as a result of isolation from their peers. One participant explained:

We're trapped here and when we have previously had one [GP] in general practice and the getting away, the renewing of themselves and all that sort of thing that they needed to keep up because things change so rapidly. ... People expect doctors to know the latest all the time if your general practitioner is flat strap, works ridiculous hours to know everything that's going on. They should be able to get away ...

3.4.5. Waiting times in practice

It was important to most participants, regardless of the geographical location, that they did not have to wait too long for their appointment with the GP. Some participants reported having to wait for over an hour at times to see their GP. Participants realised that sometimes this was unavoidable, however, if the GP was running late, they would like to be informed so they could return to the practice closer to their appointment. As two participants stated:

Oh I wish they wouldn't keep you waiting, even though my doctor has stopped bulk-billing and has done for eighteen months now, you know her idea was that she would be able to give more time to the patient and that she would, because she'd charged, she'd lose a lot of the bulk-billing customers but you know I'm still waiting an hour, hour and a half every time I go to see her.

I think my biggest grievance about visiting my doctor is the time I have to wait now. Two or three years ago and I've been coming to town to this clinic for quite some years and it was perhaps ten or fifteen minutes but now it's an hour or more.

3.4.6. Practice waiting room environment

Participants noted that the environment of the waiting room is important. Areas of concern about the waiting room were sufficient chairs, the cleanliness and noise from either the television or children. All of these issues impacted upon the perceptions of the efficiency of the practice. Some participants commented:

But the doctor's surgery itself, the waiting room environment when I moved up here... I tried to find one up here and I found it, you know like if you were sick to

start with you felt like you were nearly dead by the time you got in there, one of them had a TV up full-bore... and it was belting out and there was screaming kids running around and you waited a good hour and a half and so if I experienced that I tended to just walk out and try another one, but I found there were a lot like that.

You can always tell if it's been cleaned can't you and that care is taken.

The waiting room environment was considered important to the Indigenous participants. They stated they felt uncomfortable in the waiting room, as they could be the only Indigenous person there. The waiting room could be made more welcoming by such things as displaying Aboriginal artwork. As one participant commented:

It shows that you actually care about them and even in that waiting room I would have Indigenous pictures up on the wall, or multicultural pictures up on the wall to make it a nice environment. Like when I came in here I have a photo of my family there for the simple reason that people realise then that I'm a family man

3.4.7. Indigenous perspective

The participants in the Indigenous focus groups considered it very important for all health professionals to attend cultural awareness programs so they have a better understanding of Indigenous cultures. Participants indicated that everyone in the practice should attend these programs regularly and that they should put into practice what they learn. The participants believed that attending cultural awareness programs would have many positive outcomes. For example, the health professional would understand that people across generations within cultures have differing needs. Additionally, appropriate cultural behaviour would mean that the health professionals would be accepted by the Indigenous people who attended the practice as part of the family. As two people explained:

If a non-Aboriginal person is willing and shows that he [sic] really wants to try and learn and be with us and learn our ways and take care of us we do really appreciate that, we do really and it's we will come to love that person and have a

high regard for them. You know that's the way we are, they then become a part of our family.

They could do that, we don't have nearly as many doctors and ... attend[ing] these things it teaches you a lot...So they should attend, everybody who practises medicine should attend. It helps you understand it a lot so I would go with that, attend cultural awareness programs. Regularly. And all the people within that surgery should attend so they know what they are talking about, like if you get an older person going in there's a total difference between that older person and a younger person so you've got to be able to go and understand more all different age groups so I would go with cultural awareness.

Participants also believed it was important that health professionals be aware of the cultural needs of Indigenous peoples especially with regard to ensuring that Indigenous patients understand their illness and any interventions required. It was also noted that it may be a cultural requirement to be attended by a person of the same gender. As two participants explained:

Not having an Indigenous person there with them to explain it to them and how they should be explained is where a lot of people fail is because we're different, we think different, we like things more hands-on...

They should be equipped for Aboriginal people yeah and I sort of feel ... with the nurses you know it's good to have a female nurse employed within the staff because some, well I suppose I can correctly say that most of the Aboriginal women, if not all don't like going to somebody, a male or somebody you know that they have to take off all their clothes to have a particular test done and that and yeah and so I think that's really important as well.

The issue stressed by all Indigenous participants was that health professionals should have good interpersonal skills. They noted that good interpersonal skills alone

could make the health professional more culturally appropriate. Conversely if the health worker does not have good interpersonal skills, no amount of cultural awareness training will make them appropriate. As two participants stated:

I mean a lot of people.... non-Indigenous...don't know how to interact with Indigenous people... They've just got to have good people skills and a little bit extra for Indigenous people.

You can have very good skills, I mean if you're not a people's person well then don't bother coming in, because nobody will want to see you.

Spending time with patients is considered amongst Indigenous people to be essential as it enables the health professional to build up a relationship with the consumer. Once a relationship has been established and the consumer is comfortable, the participants believed they would trust the person with confidential information about their health. This relationship was seen to allow the health professional to better meet the needs of the Indigenous person. As two participants explained:

A good length of time with the doctor not a quick visit as they sometimes are. So you don't feel like you're in a hurry when you get in the door.

They'll start breaking, just break down the barrier there and that, people will just start talking, sometimes it just, it takes time, you've got to take a little bit of extra time to sit down and talk to them once they feel comfortable. A lot comes from being comfortable.

It was also considered important to respect people as an individual. This involved respecting the different ways people live. In particular, it was important to the participants that health professionals not believe they were culturally superior. The participants stated that Indigenous people are becoming more confident in their

needs and attitudes. However, the participants stated that many non-Indigenous people do not show respect for Indigenous people and their culture. Two participants stated:

Aboriginal people are becoming stronger and stronger and they are saying, 'I look you in the eye and you look me in the eye, but it's the way that you look at me, it's the way that you look at me'. You know that saying looks can kill and Aboriginal people get that you know they experience that a lot in the wider community.

Be open I mean a bit of that respect stuff and that common courtesy stuff and all of that is what that person will need to have to be able to build that relationship.

Similar to the findings of this study from the non-Indigenous participants, the Indigenous participants also stressed that they are individuals first. They noted that they are not a homogenous group. Rather, they are made up of many sub-cultures within the one recognised culture. Attitudes and beliefs within these sub-cultures will vary according to their up-bringing and geographical location. Two participants explained:

Different culture, like even with Indigenous people lead different tribes, come from different places, you get taught different things... So we're all from one country but we're all different tribes so depending on where we come from, you know, and how we were brought up at home strict, or not strict, so it's the background. Yeah the different geographical locations ... Aboriginal people ... yeah they come from different backgrounds.

... Like when I'm talking about respect ..., I don't like going to a doctor who will look at me and say, "oh Indigenous, oh okay", and then start thinking about all my different health problems you know or looks at some of my other community may have, and I like to be looked at as an individual and some of my health problems – not every Indigenous person has diabetes, ... or heart problems, you've got to look at me, I'm [name] first before I am anybody else.

The Indigenous participants interviewed believed that health professionals should have a good knowledge and appreciation of the individual's family history. This enabled the health worker to gain a greater insight into the person's life and environmental factors that affect their life. The participants believed that with this insight the health professional would be able to have a greater understanding of the individual's health needs and what impacted upon them. Two participants stated:

A doctor that's respectful knows me well. I don't mean clinically he knows me like personally, he knows my family, he knows some of the issues that I would discuss so that's basically the doctor I deal with. He knows me and my family he knows some of ... my work stuff as well. This means that if I'm having problems he may not think its clinical it may be something to do with work.

It's just important for people who are providing a service to actually get to know what dynamics there are in families.

3.5. Collaborative relationships – based on communication between General practitioners, practice nurses and patients

The participants in this study believed the patient played an integral part in decision-making regarding their treatment, together with the GP and PN. They believed that communication between the PN and the GP should be of high quality to insure a high level of care for the consumer. As one person stated:

I still reckon it all comes back to communication. If you've got good communication between the doctor and the nurse and the doctor and nurse with the patient it makes a lot of difference.

In the Indigenous group the GP and PN were seen as having two distinct roles. While each role was different, the Indigenous participants believed that the GP and the PN were equal along with others in the practice including the patient. They considered

that each person had different skills to contribute in being part of the team to provide care to the benefit of the patient. As one participant commented:

Just have really good communications because I mean that's basically what it's all about. Hav[ing] good communication is not a power play thing it's just, they're basically equal partners in it because that's what you want them to be...But you obviously want the doctor to have a bit more information, in a specialised area..

Similar to the Indigenous participants in this study, rural participants saw the PN and GP as a team with each contributing to the care of the patient. The GP was seen as the team leader. However these participants valued nursing input into decision making in regard to treatment. It was thought that information should be free flowing between GP, PN and patient. As one person stated:

A flexible one. That the nurse should be able to discuss things, but the doctor may not be always right either, or vice versa and that's how I, and that's how it is at our centre. ... That's why I'm comfortable in going there because the nurses and the doctors are very open, discuss your information...and whatever's happening and yeah you feel confident with either one of them coming in. They talk to you openly, there's no discussing your case behind your back and you're thinking, 'oh what are they talking about', you know, 'is it something bad, is it something good', sort of thing, they are very open. But yeah I think it should be just a free-flowing of information between doctors and nurses.

In contrast, in remote areas, the participants believed that the GP should order all treatment, and if necessary the GP would refer appropriate patients to the PN for care. The remote area participants were more inclined to see the PN in a subservient or 'handmaiden' role to the GP. However, they stated that good communication was important between the GP and the PN and that the PN should report back to the GP. As one participant explained:

I'd probably want to see the doctor first. If he[sic] decided all I needed was the nurse to come back, because that's why I'd be coming here would be to see a doctor...To see the doctor and he refers you onto the nurse, you're quite happy because he's obviously got the confidence in that nurse to do what he tells her.

In regional areas, the GP was seen as the conspicuous leader, however, both patient and PN needed to be involved in discussions regarding care. Participants believed that this team involvement would ensure that not only are all parties aware of what the GP wants, but that better care is able to be achieved by gaining input from all concerned. As one participant commented:

Maybe a consultation with all three together so that a treatment program could be worked out for that particular patient whatever they expect of them. But maybe you know...so the doctor's involved, the nurse is aware of what the doctor wants and the patient is aware of giving your opinions to both the doctor and the nurse at the same time about what they feel that they might need.

Participants in metropolitan areas provided a different perspective to others. They described the PN as the first person that a person would see – similar to a triage role. After assessment, the PN would then refer the patient to the GP if the problem was beyond the PN's scope of practice. Similar to other participants, the GP and PN were seen as a team, with each having input into patient care. As one participant stated:

I think that it's important that nurse, the practice nurse was a part of the team, you know there's equal, it's an equal playing field...But I know doctors and nurses aren't sort of equal, but they're all part of a team. Because the reception staff need to identify if some people aren't looking serious, you know maybe symptoms that this person shouldn't have ... so that everybody is sort of working as a whole team. So that's how I sort of want a practice nurse. I feel that I would have the trust in a practice nurse if that doctor also integrated ... that practice nurse [a]s part of the sort of corporation of things.)

Participants who lived in an outer metropolitan saw the relationship between the PN and GP as being bi-directional with both collaborating to provide care to the patient. Good communication between the GP and the PN was seen as essential to the provision of quality care. The PN was trusted to work within their scope of practice and refer to the GP when needed. However, participants wanted the GP to have the ultimate control of their treatment. As one participant commented:

But if you've got a wound or something and you know maybe the doctor needs to just glance, you know it might only take him[sic] two seconds to say that's fine but I suppose we all want to get back to that he has the final say in the medication and the actual authority over your treatment...It doesn't matter who administers it you know but as long as he has he final authority.

Communication, therefore, was seen to be able to occur in various ways. Participants stated the nurse should report on aspects of patient care in patient records (paper or electronic). They believed that if the PN had concerns about a patient's condition they should be able to consult with the GP verbally. Additional to these methods of communication, the participants believed that meetings should be held to discuss patient's care needs. These meetings, it was thought, should be held on a regular basis to enable both the GP and PN to have input into patient care. This would also ensure the GP was informed of the care their patients had received. These conferences or team meetings, between the patient, PN and GP were also seen as being important to the holistic care of patients. As one participant stated:

Maybe a consultation with all three together so that a treatment program could be worked out for that particular patient whatever they expect of them...So the doctor's involved, the nurse is aware of what the doctor wants and the patient is aware of giving your opinions to both the doctor and the nurse at the same time about what they feel that they might need.

3.6. Payment of Practice Nurses and GPs

3.6.1. Practice Nurse Payment

At the time of the study, in order for the practice to get paid for the work of the PN, the GP had to see the patient each visit. Participants were asked if they agreed with this payment model and if not, what alternative model would be acceptable to them.

Most participants thought that if the PN was providing a service, then they were entitled to charge for that service. Although some participants stated they would like the GP to check the nurse's work they did not believe this should occur every visit. This practice, they stated, was unwarranted and often wasted both the patient and GPs time. As one person stated:

I think the nurse should be able to charge for minor things because you know it's a bit silly if you're going to take responsibility away from the doctor for minor things and then he's [sic] got to be dropping in to give his opinion or whatever. So no I think for minor things the nurse should be able to charge them.

However, some participants noted that if they were required to pay to see the PN, they would prefer to see the GP.

3.6.2. Payment of the General Practitioner

Many participants were happy to pay above the scheduled fee for GP services. However, bulk-billing was a priority for people on pensions, Indigenous people, people with mental illness and those with chronic diseases. Many participants stated that either they were being bulk-billed in a non-bulk-billing practice due to their chronic illness or that they knew of practices that were making allowances for patients in need. Participants believed that if those in need were not bulk-billed they either would not obtain health care or they would go to Emergency Departments at public hospitals. As a participant with a mental illness stated:

I think it's dangerous not being bulk-billed, especially like in the mental health people, serious mental health because they won't go to the doctor anymore ... and so they could get really sick and it could be dangerous.

Participants who had experienced access to an Indigenous community controlled health service noted that a reliance on bulk-billing could create a health centre too reliant on a GP and the income from this GP. They believed that consumers should be able access the health professional that best met their needs, rather than being forced to see the GP on each visit as this was the only way that the health centre could generate income. As one individual stated:

We don't get a lot of money from bulk-billing because it's like, community controlled health services wouldn't have anything to do with bulk-billing. Bulk-billing makes you dependent upon the doctor. These services are not dependent upon doctors. Then again we didn't want our people coming in and just going like this while we're making heaps of money. Money's not the big thing, it's about appropriate care for each one of us at whatever level of care we may need and therefore bulk-billing, I think we only make very little money from bulk-billing.

3.7. Conclusion

This section has presented the results of the thematic analysis of the data. The next chapter will outline the quantitative results collected by the questionnaire given to all participants in the focus groups and interviews.

4.0. QUANTITATIVE RESULTS

This section reports on the results of the questionnaire that was completed by participants in this study who attended the focus groups and interviews (N=106).

4.1. Demographics of participants

Of the 106 participants, 17.9% were male, and 82.1% were female. Table 4.1 presents the age distribution of the participants in the study.

Table 4.1: Aged Distribution of Participants

Age Group	N	%
<20	2	1.8
20 to <30	13	12.3
30 to <40	13	12.3
40 to <50	16	15.1
50 to <60	20	18.9
60 to <70	21	19.8
70 to <80	16	15.1
80 plus	5	4.7
Total	106	100

Approximately 58% of the patients in this study ($N = 62$) were over 50 years of age, with the age group 60 to < 70 years predominating with 19.8% ($N = 21$). Chi square analysis revealed that there were significant differences in age between patients from the five different localities, with Longreach and Roma having a larger number of participants who were younger than 50, and Toowoomba, Brisbane, and Gold Coast have a larger number of participants who were older than 50 years, $\chi^2 (4) = 19.32, p < .05$ (see Table 4.2).

Table 4.2: Location of where participant lived according to Age

	Age		Total (N)
	Less than 50 years of age(N)	50 years of age and older (N)	
<i>Gold Coast</i>	3	18	21
<i>Brisbane</i>	9	13	22
<i>Toowoomba</i>	6	15	21
<i>Longreach</i>	11	4	15
<i>Roma</i>	14	7	21
<i>Missing values</i>			6
Total	43	57	106

As only a small number of participants were under 20 and over 80, these data were recoded into a new variable with the following categories: < 30, 30 to < 40, 40 to < 50, 50 to < 60, 60 to < 70, 70 plus. Using these revised age categories, there were no differences in ages between the gender of patients, $\chi^2 (5) = 7.65, p >.05$; how often the patient had seen their GP, $\chi^2 (10) = 12.50, p >.05$; whether the GP's surgery had a nurse employed, $\chi^2 (10) = 18.28, p >.05$; the length of time the surgery had a practice nurse employed, $\chi^2 (5) = 8.71, p >.05$; and whether patients had contact with a practice nurse, $\chi^2 (5) = 5.66, p >.05$. Overall, older patients who were involved in the study were from the coast areas, and younger participants were from the rural regions.

There were five main locations in which participants lived: Gold Coast, Brisbane, Toowoomba, Longreach, and Roma. Table 4.3 presents the distribution of participants with respect to their location.

Table 4.3: Distribution of Participants according to Location

	N	%
<i>Gold Coast</i>	21	21.0
<i>Brisbane</i>	22	22.0
<i>Toowoomba</i>	21	21.0
<i>Longreach</i>	15	15.0
<i>Roma</i>	21	21.0
<i>Missing values</i>	6	
	106	100.0

Chi square analysis revealed that there were no significant differences in place of residence between gender, $\chi^2 (4) = 8.13, p >.05$, how often participants had been to see a GP, $\chi^2 (8) = 13.17, p >.05$, whether the GP's surgery had a nurse, $\chi^2 (8) = 8.65, p >.05$, length of time the practice had a nurse, $\chi^2 (8) = 11.16, p >.05$, and whether the participant had contact with a practice nurse, $\chi^2 (4) = 1.61, p >.05$.

Of the total sample, 24% ($N = 25$) of participants had young children, 35.6% ($N = 37$) had a chronic disease, 4.8% ($N = 5$) came from a non-English speaking background, and 20.2% ($N = 21$) were over 70 years of age.

4.2. Status of nurse at GP's surgery and knowledge of qualifications of practice nurse

Patients were asked whether the GP surgery which they attended employed a PN. Most of the participants indicated that the GP's surgery employed a PN (see Table 4.4).

Table 4.4: Distribution of Participants indicated whether the GP's Surgery had a Nurse

	N	%
<i>Yes</i>	83	78.3
<i>No</i>	6	5.7
<i>Not sure</i>	17	16.0
Total	106	100

Of those who answered 'yes' to the above question, 81.3% ($N = 65$) indicated that their GP surgery had a PN for more than 12 months; 5% ($N = 4$) had employed a practice nurse within the past 12 months; and 13.5% ($N = 11$) were not sure. The majority of participants in this study (71.7%, $N = 71$) had contact with a PN. However, most participants in the study (80%, $N = 72$) did not know the qualifications of the nurse at their practice.

4.3. Number of GPs in the practice and their gender, and the major reasons for attending the GP

Table 4.5 indicates that there were predominantly between 2 and 5 GPs at practices that the participants involved in this study attended.

Table 4.5: Number of GPs working at the Practice

	<i>N</i>	%
<i>One</i>	24	22.6
<i>Two to Five</i>	62	58.5
<i>Six to Ten</i>	16	15.1
<i>more than Ten</i>	2	1.9
<i>Missing</i>	2	1.9
Total	106	100

As indicated in Table 4.6, 97% ($N = 94$) of practices had male GPs and 85% ($N = 74$) had female GPs.

Table 4.6: Participants indicating whether the GP’s surgery had Males and Female GPs

	Yes		No	
	<i>N</i>	%	<i>N</i>	%
<i>Practice has male doctors</i>	94	96.9	3	3.1
<i>Practice has female doctors</i>	74	85.1	13	14.9

Participants were asked to indicate the major reasons for their attendance to the GP. Table 4.7 provides an indication of the major reasons why the participants attended

the GP, with prescription renewal (62.3%) and health assessment or screening (56.6%) the most commonly cited reason for attending the GP.

Table 4.7: Major reasons for attending the GP

	Yes		No	
	Count	%	Count	%
<i>Prescription renewal</i>	66	62.3	40	37.7
<i>Health assessment or screening</i>	60	56.6	46	43.4
<i>Pap smears</i>	43	40.6	63	59.4
<i>Diagnosis and treatment of periodical illnesses</i>	38	35.8	68	64.2
<i>Management of chronic disease</i>	37	34.9	69	65.1
<i>Referral to other health practitioner/service</i>	37	34.9	69	65.1
<i>Diagnosis or treatment of acute illness</i>	28	26.4	78	73.6
<i>Immunisation</i>	25	23.6	81	76.4
<i>Counselling or other mental health service</i>	9	8.5	97	91.5

4.4. Preference for information regarding changes at General Practitioner’s surgery

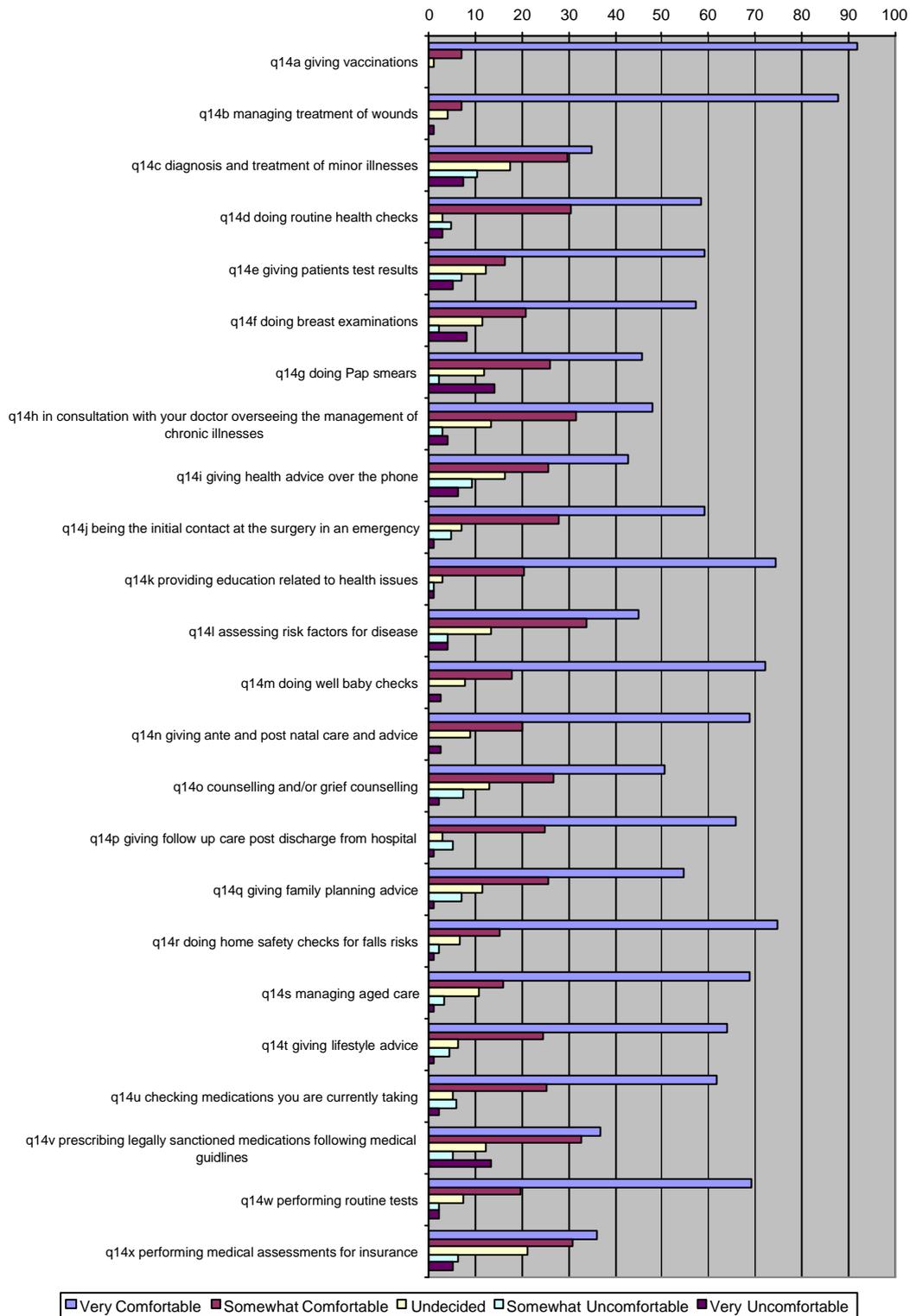
Of those who responded to this question, a majority wanted to be advised by letter from the practice (62.4%, $N = 58$). The second preference for notification was advice through a newsletter (33%, $N = 30$). The least preferred options for advice included television (2.2%, $N = 2$), and radio (2.2%, $N = 2$).

4.5. Level of comfort with practice nurse

Participants were requested to indicate how comfortable they would be with a PN providing a range of different services. They responded on a five-point Likert scale where 1 was very comfortable, 2 was somewhat comfortable, 3 was undecided, 4 was somewhat uncomfortable and 5 was very uncomfortable

The data in Figure 4.1, suggest that the participants were comfortable with all of the services that PN could provide. Participants seemed to feel most comfortable (over 70% of participants very comfortable) with PNs giving vaccinations, managing the treatment of wounds, performing home safety checks for falls risks, providing education related to health issues, and doing baby checks. The areas that participants were less comfortable (less than 40% very comfortable) with were: diagnosis and treatment of minor illnesses, performing medical assessments for insurance, and prescribing legally sanctioned medication following medical guidelines. However, it should be noted that less than 20% were uncomfortable with PN performing these tasks.

Figure 4.1 Percentages of Participants responding to how comfortable they were with the Practice Nurse performing the above Services



Further analysis of the data was then undertaken and is described on the following pages.

4.5.1. Descriptive statistics for items – level of comfort with practice nurse scale

Table 4.8 presents the descriptive statistics for items related to the participant's level of comfort with tasks to be undertaken by the PN.

Table 4.8: Descriptive statistics for tasks to be undertaken by PNs

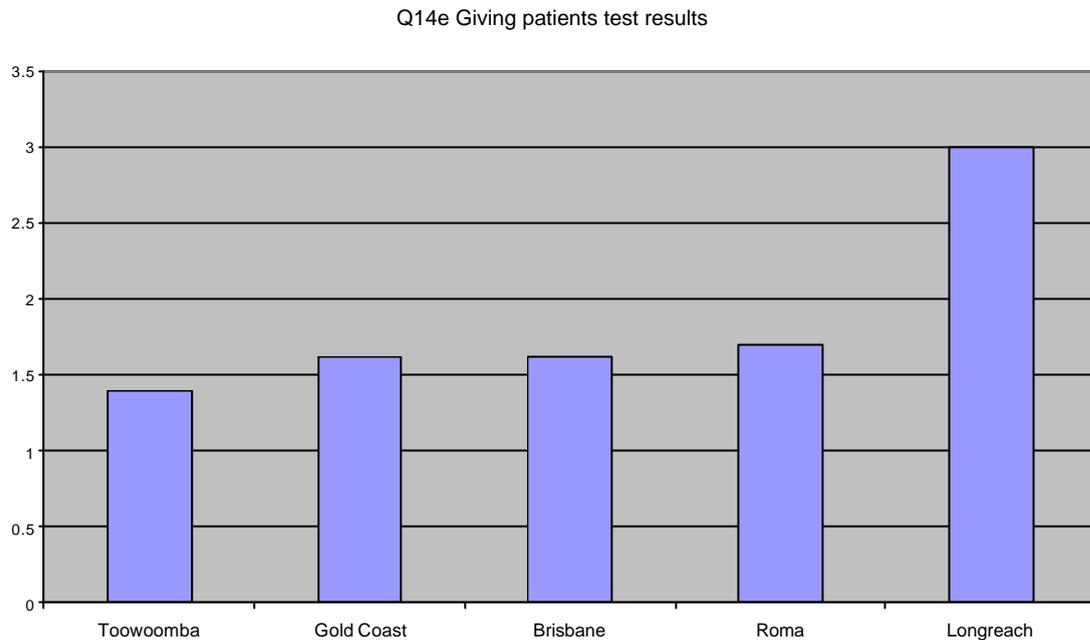
Task	Mean	Standard Deviation
<i>q14a giving vaccinations</i>	1.09	0.32
<i>q14b managing treatment of wounds</i>	1.19	0.60
<i>q14c diagnosis and treatment of minor illnesses</i>	2.26	1.24
<i>q14d doing routine health checks</i>	1.65	0.98
<i>q14e giving patients test results</i>	1.84	1.20
<i>q14f doing breast examinations</i>	1.83	1.22
<i>q14g doing Pap smears</i>	2.14	1.40
<i>q14h in consultation with your doctor overseeing the management of chronic illnesses</i>	1.85	1.05
<i>q14i giving health advice over the phone</i>	2.10	1.23
<i>q14j being the initial contact at the surgery in an emergency</i>	1.62	0.90
<i>q14k providing education related to health issues</i>	1.34	0.69
<i>q14l assessing risk factors for disease</i>	1.89	1.05
<i>q14m doing well baby checks</i>	1.43	0.84
<i>q14n giving ante and post natal care and advice</i>	1.48	0.86
<i>q14o counselling and/or grief counselling</i>	1.85	1.06
<i>q14p giving follow up care post discharge from hospital</i>	1.51	0.87
<i>q14q giving family planning advice</i>	1.74	1.00
<i>q14r doing home safety checks for falls risks</i>	1.40	0.81
<i>q14s managing aged care</i>	1.52	0.90
<i>q14t giving lifestyle advice</i>	1.54	0.88
<i>q14u checking medications you are currently taking</i>	1.62	0.98
<i>q14v prescribing legally sanctioned medications following medical guidelines</i>	2.27	1.36
<i>q14w performing routine tests</i>	1.49	0.88
<i>q14x performing medical assessments for insurance</i>	2.14	1.14

4.5.2. Analysis of variance – items in level of comfort with practice nurse scale

Analysis of variance was conducted with each level of comfort with PN item as the dependent variable, and age, location, and frequency of contact with GP as the independent variables. No statistically significant effects were found between age groups and each of the items in the level of comfort with PN scale. Also, there were no differences according to the number of times that patients had contact with their GP in the last twelve months. However, there were some differences in items according to location.

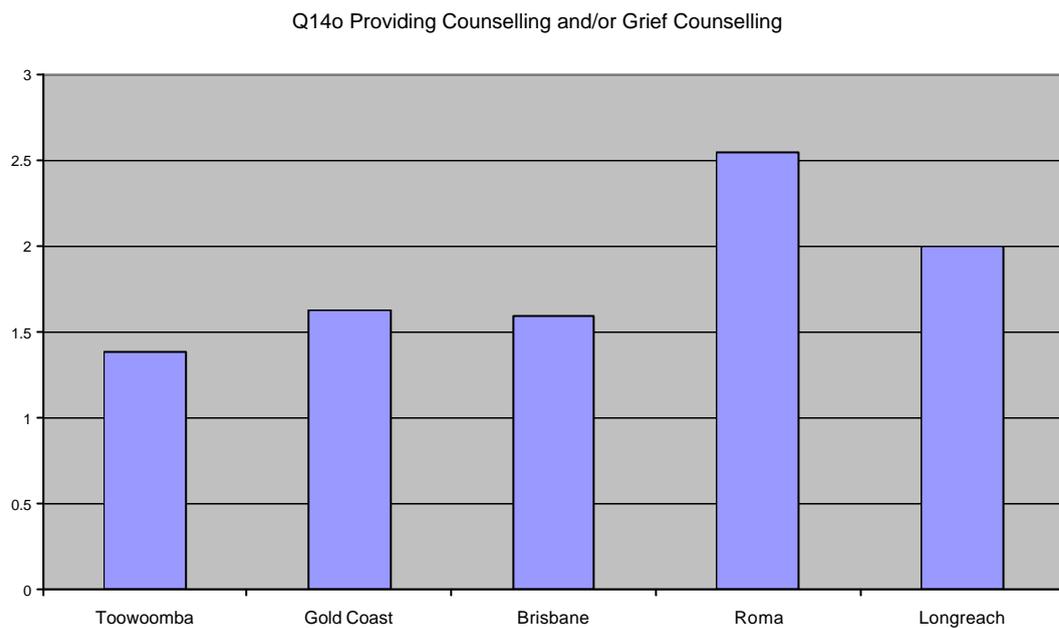
Statistically significant effects were found between the location and the level of comfort with PN giving patient tests results $F(4, 87) 5.59 < .05$. In this analysis, homogeneity of variance according to Levene's test ($2.27, p > .05$) could be assumed. Post hoc analyses, using Least Square Difference test, with Bonferonni adjustment, were conducted. Significant differences were found between Longreach and Toowoomba ($t = -1.61, p < .05$), Longreach and Gold Coast ($t = -1.39, p < .025$), Longreach and Brisbane ($t = -1.3810, p < .0125$), and, finally Longreach and Roma ($t = -1.30, p < .005$). These tests indicate that the participants from Longreach were more undecided and possibly less comfortable with PN giving test results than those participants who were from Toowoomba, Gold Coast, Brisbane, and Roma (see Figure 4.2).

Figure 4.2. Level of Comfort with PN giving patient's test results according to location



Statistically significant effects were found between the location and the level of comfort with PN providing counselling or grief counselling $F(4, 84) 4.02 < .05$. In this analysis, homogeneity of variance according to Levene's test ($1.51, p > .05$) could be assumed. Post hoc analyses, using Least Square Difference test, with Bonferonni adjustment, were conducted. Significant differences were found between Roma and Toowoomba ($t = -1.16, p < .05$), Roma and Brisbane ($t = -.95, p < .025$), and, finally Roma and Gold Coast ($t = -.93, p < .0125$). These tests indicate that the participants from Roma were more undecided and possibly less comfortable with PN providing counselling or grief counselling than those participants who were from Toowoomba, Brisbane, and Gold Coast (see Figure 4.3).

Figure 4.3 Level of Comfort with PN providing counselling according to Location



4.5.3. Exploratory factor analysis of level of comfort with practice nurse scale

Results of the factor analyses of the Level of Comfort with PN data are presented in this section. Exploratory factor analysis was recognised as the most appropriate method for establishing the underlying factor structure of this new questionnaire.

The questionnaire contained 25 items to be factor analysed. For evaluating the factorability of the correlation matrix, Bartlett's test of sphericity (1950, 1951) and the Kaiser-Meyer-Olkin's (Kaiser, 1970, 1974) measure of sampling adequacy (MSA) were employed. Principal axis factoring with oblique rotation was conducted on each section. To facilitate extraction of factors, the criteria: Kaiser-Guttman eigenvalue rule (Guttman, 1954; Kaiser, 1960, 1970) and Cattell's (1966) scree test were used. Criterion for deletion of items was considered, with communalities below .20, poorly loading variables, and complex variables considered for deletion. Decisions in all cases were carefully considered in terms of item content and factor analytic outcomes. Bartlett's test of sphericity was applied, and the Kaiser-Meyer-Olkin's MSA was calculated to determine the factorability of the matrix. On both counts, the matrix was deemed to be factorable with c^2 , 1480.21, $p < .001$ and MSA = .82. After PAF was applied with oblique rotation to determine the factor loadings, the full set of 25 items was retained. Four factors were extracted, and as indicated by the communality values (h^2), as seen in Table 1.9, ranged from .20 to .54, which would indicate

homogeneity among the items. With a cut off of .30 for inclusion of a variable in interpretation of the factor, all of the items loaded in the solution. Loadings of variables on factors and communalities are shown in Table 4.9. Variables are ordered and grouped by size of loading to facilitate interpretation. Contrary to the above, Cattell's (1966) scree test suggested one factor as an alternative solution (see Figure 4.4). The one-factor solution accounted for 37.52% of variance. As the one factor solution was preferred, the four factors on the four factor solution were not interpreted nor given labels.

Table 4.9: Factor Loadings, Communalities (h^2) for Principal Axis Factoring and Oblique Rotation on Level of Comfort with PN scale (4 and 1 Factor Solutions)

	F ₁	F ₂	F ₃	F ₄	F ₁	h^2 (extracted)
Q41v Prescribing legally sanctioned medications following medical guidelines	.85	-.07	-.01	-.08	.68	.46
Q14u Checking medications you are currently taking	.76	.18	-.03	.05	.73	.54
Q14c Diagnosis and treatment of minor illnesses	.73	.07	.18	-.07	.54	.29
Q14x Performing medical assessments for insurance	.65	.00	-.11	-.13	.69	.47
Q14d Doing routine health checks	.65	.07	.04	-.03	.57	.32
Q14i Giving health advice over the phone	.58	.04	-.07	-.09	.61	.37
Q14l Assessing risk factors for disease	.49	-.13	-.27	-.19	.63	.40
Q14e Giving patients test results	.46	.05	-.20	-.07	.61	.37
Q14j Being the initial contact at the surgery in an emergency	.40	.15	-.26	.20	.52	.27
Q14h In consultation with your doctor overseeing the management of chronic illnesses	.38	.07	-.32	-.06	.64	.41
Q14b Managing treatment of wounds	.22	.76	.04	.08	.61	.37
Q14a Giving vaccinations	.07	.74	.15	-.02	.45	.20
Q14m Doing well baby checks	-.18	.63	-.14	-.36	.58	.33

Q14n	Giving ante and post natal care and advice	-.26	.56	-.24	-.40	.56	.31
Q14k	Providing education related to health issues	.10	.51	-.27	.05	.61	.37
Q14o	Counselling and/or grief counselling	.20	.40	-.25	.00	.63	.40
Q14s	Managing aged care	-.01	-.06	-.86	-.13	.67	.45
Q14r	Doing home safety checks for falls risks	-.09	.13	-.75	.02	.57	.32
Q14w	Performing routine tests	.30	-.02	-.56	.04	.63	.40
Q14p	Giving follow up care post discharge from hospital	.37	.08	-.51	.01	.73	.54
Q14t	Giving lifestyle advice	.13	.08	-.38	-.25	.59	.34
Q14g	Doing Pap smears	.23	.00	.08	-.74	.53	.28
Q14f	Doing breast examinations	.12	.04	-.03	-.72	.54	.29
Q14q	Giving family planning advice	.07	.30	-.28	-.45	.72	.52
	Eigenvalue (final value)	9.18	2.03	1.18	1.01	9.00	
	Percent of Variance (final value)	38.24	8.47	4.89	4.19	37.52	

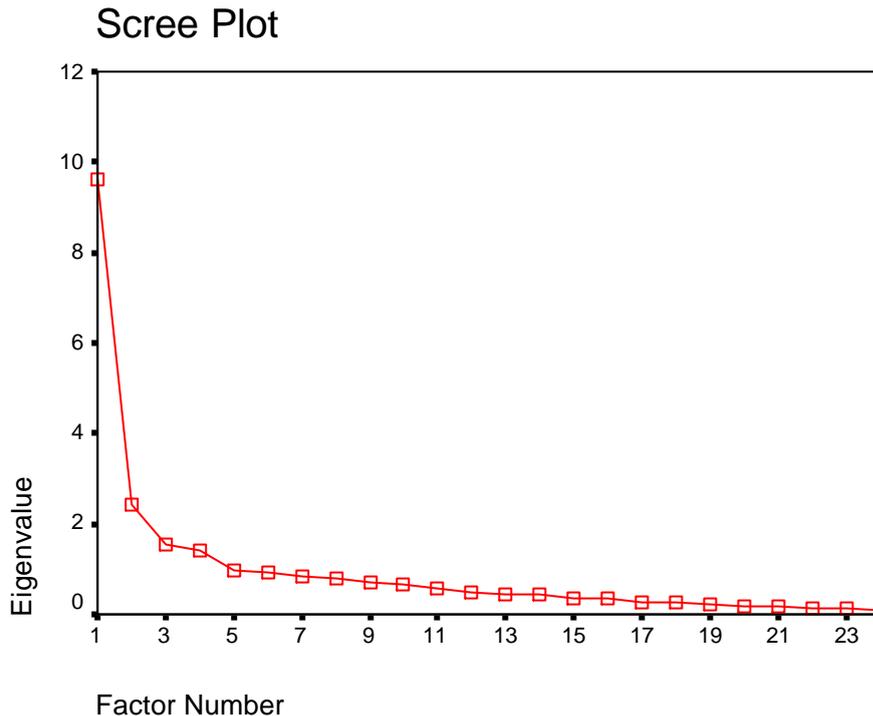


Figure 4.4. Scree plot of level of comfort with practice nurse items

The findings reported here suggest that the level of comfort scale is tapping a general Level of Comfort with PN factor. Based on the factor solution above, the scale Level of Comfort with PN scale (COMFORT) was formed.

4.5.4. Descriptive statistics for level of comfort with practice nurse scale

The skewness and kurtosis of the scale was examined to assess normality. The Level of Comfort with Practice Nurse Scale had moderate kurtosis. A variety of options were explored to improve the normality of this variable, including square root transformation of the data. As none of the options appreciably improved the data, no transformations were conducted. Patterns of skewness in the variables suggested a violation of the assumption of linearity. Given that it was impractical to examine all pairwise combinations of variables, scatterplots were conducted on pairs of strongly skewed items. An examination of these plots indicated that linearity of the variables could be assumed. Examination of Levene’s test of Homogeneity of Variance indicated that homogeneity of variance could not be assumed on all analyses. To reduce the chance of the tests overestimating the differences, a more stringent level of significance was applied. The mean score for this 25 item

scale was calculated at 1.68, with a standard deviation of .62. The reliability coefficient (i.e., Cronbach's α coefficient) for this scale was .93 which represents good internal consistency (Murphy & Davidshofer, 1991).

4.5.5. Analysis of variance and independent samples T-Tests

Four analyses of variance were performed on Level of Comfort with PN. Independent variables consisted of age, and location, the frequency patients had visited their GP in the last year, and the number of GPs working at the practice. As one of the categories in the variable that measured the number of GPs working in the practice had a small number of data points, this variable was recoded. The new categories were: one, two to five, and more than six.

No statistically significant effects were found between age groups and level of comfort with PN, $F(7, 91) = 1.66, p > .05$. Also, there were no differences in level of comfort with PN according to location, $F(4, 89) < 1, ns$. There were no differences in the level of comfort according to the number of times that patients had contact with their GP in the last twelve months, $F(2, 96) < 1, ns$. Finally, the number of GPs working at the practice had no bearing on the level of comfort with the PN, $F(2, 98) < 1, ns$. In other words, there were no differences between the age groups in their level of comfort with PN. Secondly, there were no differences in where the participant lived, or how frequent they had seen the GP in the last year. And, finally the level of comfort was no different if there was one GP, two to five GPs, or more than six GPs working in the practice.

Two independent sample t-tests were conducted on Level of Comfort with PN. Independent variables included gender and contact with a practice nurse. In both tests, no significant differences were found. In the first test, males level of comfort with PN ($M = 1.59, SD = .47$) was not significantly different from females level of comfort with PN ($M = 1.70, SD = .64$), $t(97) = .715, p > .05$. In the second test, for the participants who had previously had contact with a practice, their level of comfort ($M = 1.66, SD = .56$) was not significantly

different from who had not had contact with a practice nurse ($M = 1.72$, $SD = .79$), $t(91) = .443$, $p > .05$.

4.5.6 Summary of quantitative results

Of the 106 participants, around 82% were female and 58% were over 50 years of age. Age was not a determinant in responses to this questionnaire. However, a larger proportion of older participants in the study were located in the Toowoomba, Brisbane and Gold Coast regions. Participants were fairly evenly distributed across the five main locations.

Of the total responses, 24% had young children, 35.6% had a chronic disease, 4.8% came from a non-English speaking background, and 20.2% were over 70 years of age.

Most of the participants indicated that their GP employed a PN, with most PNs being employed for more than 12 months. The majority of participants in this study had contact with a PN, but did not know the PN's qualifications. The majority of surgeries had between two and five GPs, with the bulk of those being male. Participants indicated that they attended the GP mainly for prescription renewals and health assessments. When changes occur to GP surgeries, respondents indicated that letters followed by newsletters were the preferred forms of advice.

Overall, participants were either very comfortable or comfortable with all the services that PNs could provide. Location was an important factor in two of the services that PNs could provide. Participants from Longreach were more undecided with a PN giving test results than participants from other areas. Also, participants from Roma were more undecided with a PN providing counselling than those from other areas.

Statistical analyses of the underlying factor structure of the Level of Comfort with PN Scale indicated an internally consistent scale that measured one dominant dimension labelled Level of Comfort with PNs. Results of this study found that this scale was independent of age, location, frequency patients

visited their GP, number of GPs working at the practice, gender and contact with the PN.

5.0 DISCUSSION AND CONCLUSION

This study aimed to ascertain consumer perceptions of practice nurses, and therefore the discussion will focus mainly on the similarities and differences between the results of this study and the study undertaken by Cheek et al. (2002a).

5.1 Demographics

The study undertaken by Cheek et al. (2002a) had a lower proportion of female participants (60% compared to 82%). However, the age groups of the participants in this study were similar with 58% over 50 years of age compared with 64% aged over 45 years in the Cheek et al. (2002a) study. A major difference in the two studies was that 57% of the participants in the Cheek et al. (2002a) study had no exposure to practice nurses, whereas 78% of the participants in this study accessed a general practice that employed a PN.

5.2 Consumer perceptions of practice nursing

The major focus of this study and Cheek et al's (2002a) study was the current and future role of the PN. The findings of both studies will now be discussed.

5.2.1. Designation of nurse and nursing activities

The common theme of these two studies was that the majority of consumers are not aware of what the role of a nurse actually is (other than what they observe as a role in the acute care setting). Further, in many cases, consumers were unaware that there are two levels of regulated nurses in Australia – enrolled or registered. Additionally, in the Cheek et al. (2002a) study, it was apparent that this lack of understanding of the role of nurses, and the high number of participants who had no contact with PN, meant that the consumer was unable to visualise expansion of the nursing role.

A contrasting finding in this study was that participants did not believe that enrolled nurses should be employed when they were the only nurse in the

practice. Additionally, the consumers in this study believed that newly graduated nurses would not have the necessary skills and knowledge for the PN role.

5.2.2 *Who does nursing work?*

A logical conclusion from both this study and the results of Cheek et al.'s study (2002a) is that if consumers are unaware of the role of nurses, then they are also unaware of the scope of nursing practice. In addition, they often assume that the person to whom the general practitioner has delegated nursing work would be a nurse (Patterson et al. 2000; Cheek et al. 2002). It was apparent that there was a high level of consumer trust – that is consumers trusted that a general practitioner would only employ a person who is suitably qualified and would only delegate work to a person who had the expertise to carry out the work in a competent manner. Unfortunately from the work of Patterson et al. (2000) we know this does not always occur.

A question which was discussed in both studies was how would the consumer recognise that the person was a registered or enrolled nurse? In both studies, consumers noted that nurses were recognised either because they were known as a nurse (this was particularly the case in small rural communities); because they had been introduced as a nurse to the consumer by the general practitioner; because they worn a name badge that identified them as a nurse; or because they worked out of a room which was identified as the 'nurse's room' within the general practice (Cheek et al. 2002).

In this study, many consumers noted that the nurse should be recognised as an equal health professional and that qualifications and certificates should be equally displayed within the general practice. This was also a finding within the Cheek et al. (2002a) study.

5.2.3 *Tasks or activities of practice nurses*

Similar to the finds of the Cheek et al. (2002a) study, the consumers in this study were most likely to feel comfortable with nurses undertaking roles that consumers were familiar with as either acute hospital or general practice

nursing roles. That is, they believed that the nurse could competently undertake wound management, performing routine tests and vaccination. In contrast to the findings in the Cheek et al. (2002a) study, over 70% of the consumers in this study also saw a major role of the PN as doing home safety checks to assess for fall risk and providing education related to health issues. The consumers in this study, in contrast to the Cheek et al. (2002a) study, were able to conceptualise that nurses in general practice could specialise in a particular area. They were quite happy for this to occur as long as the nurse was appropriately qualified in this speciality and continued to remain clinically current in this speciality area. Similar to the Cheek et al. (2002a) study, consumers assumed that nurses would only practice if they were competent to do so.

The level of agreement between consumers in regard to what they would accept as a PN role, varied between geographical location. In particular, consumers from remote areas such as Roma and Longreach were less likely to agree that the provision of test results and counseling was a role of the PN. These geographical differences were not reported in the Cheek et al. (2002a) study.

5.2.4 Difference in the role of the practice nurse and the general practitioner

The consumers in this study believed that nurses, on the whole, were more focused on the delivery of holistic care. In the Cheek et al. (2002a) study, carers and people with a chronic illness also believed that the PN would deliver more holistic care rather than just focusing on the disease process. Additionally, this holistic care would be complemented by good communication between the GP and the PN (Cheek et al. 2002).

5.2.5 Future activities of practice nurses

Geographical differences were evident in this study with regard to what consumers would see as a future activity of PN, particular with regard to the ability of the nurse to work as an individual health professional rather than under the supervision of a general practitioner. Consumers in more remote

areas were very concerned that nurses may take on a diagnostic role, and they did not believe this was a role of the nurse. In contrast, consumers in rural areas were comfortable with nurses undertaking a diagnostic role. These findings contrast with Cheek et al.'s study where the majority of participants did not see diagnosis as the role of a nurse.

The gender of the PN also appeared to suggest activities of the PN. For example, in both studies the participants suggested that women's health issues such as Pap smears would be a role for a female PN as long as they were suitably qualified to undertake these tasks (Cheek et al. 2002).

Triage (seen as sorting process rather than triage using the Australasian Triage Scale) was another area that many consumers believed should be the role of the PN in both studies. The triage was seen as being either telephone or face-to-face with the nurse undertaking an initial assessment and then making a decision about the need to see the general practitioner as well as the urgency for the consultation. This role, however, was acceptable only if it was not used as a method of gatekeeping and thus keeping consumers from accessing the general practitioner (Cheek et al. 2002)

5.2.6. *Benefits of practice nurses*

Consumers in both studies noted that a positive outcome of an expanded PN role was that there would be more GP time. Consumers in the Cheek et al. (2002a) study saw this time to be used to enable more throughput through the practice, thus maintaining the income stream of the GP. In contrast, many of the consumers in this study believed that the extra time generated could be used to ensure longer consultations with the GP. They also noted that workload issues for the GPs were such that any quality service which could lessen GP workload would advantage the GP as well as the consumer.

5.2.7. *Acceptance of change within general practice*

Cheek et al.'s (2002a) findings suggest that if the GP personally introduces the PN to the consumer or introduces him/her through newsletter then people would accept the nurse and would not ask about qualifications. The

consumers in this study also believed that the use of a Newsletter to clients of the general practice introducing the nurse and explaining the role would be the preferred communication option.

5.2.8. Practice nurses and general practitioners working as a team

Consumers in both studies believed that the GP needed to treat the PN as an equal. Whilst the consumers in Cheek et al's (2002a) study believed that it was good practice for the PNs and GPs to discuss cases without the consumer present, the consumers in this study – particularly the Indigenous consumers, believed that the team should include the patient.

A finding not evident in this study, which was discussed in the Cheek et al. (2002a) study was that PN could be used to provide a second opinion.

5.2.9. Confidentiality and privacy

Consumers from both studies who were located in small rural or remote towns, noted that confidentiality and privacy was an issue (Cheek et al. 2002). Additionally, in this study there was some concern raised that as the PN was on the same social level as the consumer, that sensitive issues were better explored with the GP.

5.2.10 Cost of practice nurse care

In both studies, consumers considered that while it would be appropriate for the PN to be paid a fee for their service, they should be paid at a lower rate than the GP (Cheek et al. 2002). Additionally consumers in both studies did not want to have to pay for visits to two health professionals if they saw the GP and the PN on the same day. Consumers in the Cheek et al. (2002a) study also believed that a MBS item should be created for PN activities such as wound dressings and removal of sutures. The Medicare Plus (2003) changes now allow PNs to raise an MBS item for immunization and wound dressings without the GP having to be involved in the consultation.

5.2.11 Indigenous peoples expectations of practice nurses

In contrast to the Cheek et al. (2002a) study, this study included the perspectives of Indigenous people. It is apparent that Indigenous people believe that health care delivered by GP and PNs should be culturally appropriate. Similar to the non-Indigenous community, Indigenous consumers believed that communication was the key to effective team building within general practice as well as effective patient/GP/PN relationships.

5.3 Conclusion

It is apparent that the majority of findings of this study are similar to the findings of Cheek et al. (2002a). Whilst there were some differences the study's findings re-enforce the key variables identified from the Cheek et al. (2002b) study. Important to the successful implementation of PN models are:

- *The working relationship between the doctor and nurse and the united front they present to clients;*
- *That nurses act in a complementary role to that of the general practitioner;*
- *Consumers choice of who they would see;*
- *Additional service costs of seeing a nurse;*
- *Consumer's trust in the nurse's abilities;*
- *Increased accessibility to their doctor;*
- *Information about nurse's qualifications and scope of practice; and*
- *The impact on the nursing workforce.*

The only key variable not raised as a major issue by the consumers in this study was:

- *Concern in regard to emerging insurance and litigation issues. (Cheek et al. 2002b p1).*

The variables that were raised in this study, that were not evident in Cheek et al.'s (2002a) study were:

- Geographical differences. For example, nurses diagnosing was acceptable in larger population centres;

- That enrolled nurses should be supervised by registered nurses and that the enrolled nurse should not be the sole nurse in the practice;
- There was a role for nurses to undertake home visiting, particularly for a safety assessment of the patient's environment;
- That PN can be generalist or specialists;
- There were differences in perceptions of the PN role that were determined by the cultural needs of people - in this case, Indigenous peoples.

It is apparent that when the two study results are combined, there is a strong message to policy makers on what consumers will expect from PNs. However, a major message from both reports is that considerable consumer education must take place on the role of the PN (both registered and enrolled) if there is to be a successful expansion of the PN role.

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7.0 APPENDICES

1. Consent forms
2. Brochure (includes plain language statement)
3. Focus Group Questions
4. Questionnaire for focus groups and interviews

**Consumer Perceptions of
Practice Nursing - Focus Groups
and Interviews**

CONSENT FORM

I _____
of _____

(address)

have read the information and agree to participate in the study. I am aware that my participation is voluntary and that I can withdraw from the study at any time by contacting Professor Hegney. I agree that the information I contribute to this study can be published as long as I cannot be identified in any way.

Telephone Contact number/s

Day: _____

Mobile: _____

Email: _____

Signed: _____

Date: _____

Witnessed: _____

**Consumer Perceptions of
Practice Nursing – Focus Groups
and Interviews**

CONSENT FORM

I _____
of _____

(address)

have read the information and agree to participate in the study. I am aware that my participation is voluntary, and that I can withdraw from the study at any time by contacting Professor Hegney. I agree that the information I contribute to this study can be published as long as I cannot be identified in any way.

Telephone Contact number/s

Day: _____

Mobile: _____

Email: _____

Signed: _____

Date: _____

Witnessed: _____

**Consumer Perceptions of
Practice Nursing – Focus Groups
and Interviews**

CONSENT FORM

I _____
of _____

(address)

have read the information and agree to participate in the study. I am aware that my participation is voluntary and that I can withdraw from the study at any time by contacting Professor Hegney. I agree that the information I contribute to this study can be published as long as I cannot be identified in any way.

Telephone Contact number/s

Day: _____

Mobile: _____

Email: _____

Signed: _____

Date: _____

Witnessed: _____

Dear Consumer

The Commonwealth government and the Divisions of General Practice have recently been directing their attention toward the role of nurses in general practice, with a view to improving the delivery of health care at practice level by providing patients with a multi-disciplinary health care team to meet their needs. In fact the last two Commonwealth budgets have seen over \$250 million set aside for the implementation of new models of nursing in general practice. Before any new nursing model can be implemented however, we feel that consumer expectations, rights and responsibilities must firstly be accounted for.

The unique circumstances surrounding health care delivery across metropolitan, regional and rural contexts in Queensland will also need to be taken into account, as consumers will most likely require a different model of Practice Nursing here than that established in other parts of Australia or overseas. This project will provide information that can be used to ensure that models of Practice Nursing are flexible, efficient and fit comfortably with community wishes for primary health care.

What is the aim of the project?

The aim of this study is to explore consumer perceptions of Practice Nursing in metropolitan, rural and remote Queensland in order to inform future policy and strategies regarding Practice Nursing.

What will be covered by the project?

This project will explore consumers understanding of the range of nursing duties in General Practice; the level of care that consumers expect from the Practice Nurse model; and their understanding of the processes involved in the delivery of primary health services that utilize Practice Nurses. The project will also seek consumers' guidance regarding strategies they believe will effectively communicate the role and responsibility of Practice Nurses to fellow consumers.

What does participation involve?

Both focus group and interview participants will firstly be asked to complete a brief questionnaire to collect some background data. The discussions themselves will be taped for later transcription (minus any identifying comments), allowing the research team to check back over the content, use direct quotes where required, and identify the major themes arising from the discussion.

Focus groups

The groups will be led by a facilitator, who will help to maintain focus on the issues at hand, and ensure all voices are heard. The discussion will involve brainstorming around questions taken from the project objectives, with participants working together to gather and prioritise ideas and information in a local context.

Interviews

The aim of the individual interviews is to elicit an in-depth understanding of the issues concerning Practice Nursing from those who do not wish to contribute their views in a focus group environment. The interview questions are identical to those used in the focus groups.

Who will be there during my focus group?

We envisage that each group will involve approximately 8-10 participants, plus the facilitator and one other member of the project team.

What's in it for me?

Initiatives such as this impact on the delivery of health care across Australia, and community members are entitled to have input into their formation. Participation affords you this valuable opportunity. A light morning or afternoon tea will also be provided.

How long will it take?

We envisage that the focus groups will take a total of approximately two hours, while individual interviews should require less time.

Where are the groups going to be held?

Groups will be held in Toowoomba, the Gold Coast, Brisbane/Ipswich, Roma and Mt Isa, allowing a mix of rural, remote and metropolitan areas of Queensland. Individual venues will be communicated to participants when available.

How to participate

If you would like to have a say in the future direction of primary health care delivery in Australia, please sign the enclosed consent form. The form includes provision for a postal address and contact phone numbers, which will allow our representative to contact you to arrange a time and place for your interview or focus group. Once you have completed the form, you can -

- Hand the form to the front desk of your doctor's surgery
- Post the form to the address printed on the back of this pamphlet
- Phone us for more information, or to arrange a time.

As with all ethical research, any information or opinions you provide will be kept in the strictest confidence. All identifying marks are removed from the data, and the research team will take every possible precaution to ensure your confidentiality is preserved. We appreciate that your good relationship with your local GP and the practice staff is of the utmost importance, and we will make every effort to ensure that your opinions are kept anonymous. If you have any particular concerns in this area, you may decide it is best to request one of the private interviews, rather than participate in a focus group environment.

Participation is entirely voluntary, you can withdraw at any time, and your medical treatment will not be affected in any way should you decide not to participate.

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This project is funded by the University of Southern Queensland 2002/2003 Research Projects Program

An Invitation



**to have a say in the
future direction of**

Practice Nursing

Focus Group Questions

1. What factors affect the quality of the service you receive from your general practice?

Prompts:

- access
- cost
- choice
- facilities
- privacy
- clinical expertise of health practitioners (HPs)
- interpersonal skills of HPs
- coordination of care
- appropriate referral to other HPs/services
- level of explanation of condition/treatment
- degree of collaboration with patient
- nurse from same cultural background e.g Indigenous

2. What does the nurses role entail in general practice and what experiences have you had with practice nurses.

3. What services do you think nurses should provide in general practice and why?

Prompts:

- triage (clinic/telephone/home)
- phone advice/counselling
- physical examination and history taking
- screening tests like Pap smears & breast examination
- general health assessment/risk appraisal
- well baby check
- ante & post natal care & advice
- diagnosis & treatment of minor illness/injury including ordering pathology & radiology tests
- coordination of chronic illness care eg diabetes, asthma, hypertension referral to other HPs/services
- health education
- grief/trauma counselling
- explanation of test results
- home visits

4. What qualifications does the practice nurse need to have to provide the services discussed

5. How do you think nurses in general practice do/will affect the care offered by the practice?

6. How do you think a GP and a nurse should work together?

7. Do you require choice in who you see
8. What should happen with the payment of practice nurses
9. If nurses were to take on expanded roles in general practice, what do you think is necessary to ensure patients' confidence and acceptance?
10. What form of identification do the nurses need and should qualifications be displayed.

QUESTIONNAIRE FOR FOCUS GROUPS AND INTERVIEWS

Please circle only one response unless otherwise instructed.

1. **Are you?**
Male _____ 1
Female _____ 2

2. **What is your age?**
<20 _____ 1
20 to <30 _____ 2
30 to <40 _____ 3
40 to <50 _____ 4
50 to <60 _____ 5
60 to <70 _____ 6
70 to <80 _____ 7
80 years of age or older _____ 8

3. **Please tell us the postcode of the town or area where you live.**

4. **In the last twelve months, how often have you seen your doctor?**
10 or more times a year _____ 1
5 – 10 times a year _____ 2
less than 5 times a year _____ 3

5. **Does the doctor's surgery you attend have a nurse employed?**
Yes _____ 1
No _____ 2
Not sure _____ 3

6. **If you answered yes, to this question, can you tell us if:**
The doctor's surgery has had a practice nurse for more than 12 months 1
The doctor's surgery has, within the last 12 months, employed a nurse 2
Don't know 3

7. **Do you know what qualifications the Nurse at your practice holds?**

yes no

8. **How many doctors work in the practice you attend?**
Only one _____ 1
2 to 5 _____ 2
6 to 10 _____ 3
More than 10. _____ 4

9. Does the practice you attend have doctors that are? (circle all that apply)

Male	yes	no
Female	yes	no

10. Are you (circle as many that apply to you)

A parent with young children _____ 1
A person who has a chronic disease such as diabetes, asthma ___ 2
A person who comes from a non-English speaking background ___ 3
A person over 70 years of age _____ 4
None of the above _____ 5

11. Could you please indicate the major reasons why you attend the doctor? (you may circle more than one)

Prescriptions/renewals _____ 1
Management of chronic disease such as asthma, diabetes _____ 2
Pap smears _____ 3
Health assessment or screening eg blood pressure check _____ 4
Counselling or other mental health services _____ 5
Diagnosis and treatment for acute illness/injury _____ 6
Referral to other practitioner/service _____ 7
Immunisation _____ 8
Diagnosis and treatment of periodical illnesses _____ 9
Other (please specify) _____ 10

12. Have you had any contact with a Practice Nurse? yes no

13. I would prefer to be informed about changes taking place at my doctor's surgery by

(Please rate from 1-7; 1 being most preferred and 7 least preferred)

Newsletter _____
Television _____
Radio _____
Newspaper _____
Letter from practice _____
Email from the practice _____
Other (please specify) _____

10. The following are services that a practice nurse could provide, following relevant training and qualifications. Please place a tick in only one of the squares to indicate how comfortable you would be with them providing that service

	Very comfortable	Somewhat comfortable	Undecided	Somewhat uncomfortable	Very uncomfortable
a) Giving Vaccinations					
b) Managing treatment of wounds					
c) Diagnosis and treatment of minor illnesses					
d) Doing routine health checks					
e) Giving patients test results					
f) Doing Breast examinations					
g) Doing Pap smears					
h) In consultation with your doctor overseeing the management of chronic illnesses i.e. diabetes, asthma, heart disease					
i) Giving health advice over the phone					
j) Being the initial contact at the surgery in an emergency					
k) Providing education related to health issues					
l) Assessing risk factors for disease e.g. heart disease, diabetes					
m) Doing well baby checks					

	Very comfortable	Somewhat comfortable	Undecided	Somewhat uncomfortable	Very uncomfortable
n) Giving ante and post natal care and advice					
o) Counselling and/or grief counselling					
p) Giving follow up care post discharge from hospital					
q) Giving Family planning advice					
r) Doing home safety checks for falls risks					
s) Managing aged care i.e. accessing services, coordinating allied health professionals					
t) Giving lifestyle advice					
u) Checking medications you are currently taking					
v) Prescribing legally sanctioned medications following medical guidelines					
w) Performing routine tests such as; ECG's and Spirometry					
x) Performing medical assessments for insurance					

y) Are there any other services you feel a practice nurse could provide?
