

**Practice nurses' perception of opportunities and barriers
to the expansion of nursing roles within contemporary
General Practice**

**Mary Carthew
A Qualitative Descriptive Study**

A dissertation submitted to Auckland University of Technology
in partial fulfillment of the requirements for the degree of
Master of Health Science (MHSc)

2011

Primary Supervisor: Dr Anita Bamford-Wade

Contents

ATTESTATION OF AUTHORSHIP	i
ACKNOWLEDGEMENTS	ii
ABSTRACT	iii
KEY TO TRANSCRIPTS	v
KEY TERMS USED.....	vi
LIST OF FIGURES	ix
LIST OF TABLES	vii
CHAPTER 1: INTRODUCTION	1
Introducing the Author.....	1
Purpose of the study	2
Background: History of Health & Practice Nurse Development in New Zealand	4
Context of this study	9
Significance of the study.....	9
Structure of the dissertation	10
Conclusion	11
CHAPTER 2: LITERATURE REVIEW	12
Introduction	12
The Primary Health Care Strategy	13
Māori Health: Whānau Ora.....	18
Collaboration, capability, capacity.....	20
Collaboration.....	21
Capability	26
Capacity.....	30
Critical social theory	33
Conclusion	38
CHAPTER 3: METHODS & METHODOLOGY	40
Introduction.....	40
Descriptive qualitative research	41
Ethical considerations	43
Participant selection	43
Informed consent.....	44
Anonymity and confidentiality	44
Data collection	45
The interview process	45
Data analysis	46
Phases of thematic analysis.....	47
Conclusion	51
CHAPTER 4: RESEARCH FINDINGS	52
Introduction.....	52
Theme 1: Expanded roles require further education.....	53
Theme 1: Sub-themes: Opportunities and barriers	55
Support: Opportunities & barriers.....	56
Family: Opportunities & barriers	60

Theme 2: Professional self esteem.....	61
Depth of understanding: Professional self esteem	61
Being valued: Professional esteem.....	62
Autonomy: Professional self esteem.....	64
Leadership: Professional self-esteem.....	65
Conclusion	66
CHAPTER 5: DISCUSSION AND RECOMMENDATIONS	68
Introduction.....	68
Implications for clinical practice.....	68
Postgraduate education.....	69
Funding	69
Support	70
Family	71
Professional self-esteem.....	71
Deeper understanding.....	72
Being valued.....	72
Autonomy.....	73
Leadership.....	74
Limitations of the study	74
Credibility	75
Transferability	76
Dependability	76
Confirmability.....	77
Areas for future research.....	77
Recommendations	78
Conclusion	78
REFERENCES.....	80
Appendix 1	88
Appendix 2.....	89
Appendix 3.....	92
Appendix 4.....	93

ATTESTATION OF AUTHORSHIP

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.”

Mary Carthew

ACKNOWLEDGEMENTS

I wish to acknowledge the team of practice nurses I work with on a day-to-day basis in my role as a primary health care nursing leader. I am constantly amazed and humbled by the work you do, and the difference you make, to our enrolled patient population.

To the four practice nurses who agreed to be interviewed for this study, I thank you sincerely for your time, your knowledge, and your commitment to our profession.

To my supervisor Dr Anita Bamford-Wade for your support, academic guidance, knowledge and encouragement during the writing of this dissertation, my sincere thanks.

Finally, my thanks and dedication of this research study goes to my manager and Chief Executive, respected long-term colleague and valued friend, Christopher Farrelly. Without your support and belief in me, and the nursing profession, I would have exited post-graduate study several semesters ago.

*Language is what allows an object to
'come into words'
It belongs to the process of understanding.
(Gadamer, p 350-351)*

ABSTRACT

The New Zealand government's plan for 'better sooner, more convenient primary health care' (Ryall, 2007) has a clear mandate for developing Integrated Family Health Centers (IFHC) which are patient-centered, lead by clinicians, cost-effective and have a focus on delivering health targets. What is not clear is how this will be achieved in practice, and how IFHC will address some of the disparities which exist in the current model of healthcare in New Zealand; a model which is based primarily on a medicalised model.

With the escalating burden of chronic disease it is essential to clearly articulate, strategise and plan how the new model will be different to the current one, and to explore what will be the role of practice nurses in the new and changing environment. The co-location of a multi-disciplinary health team presents opportunities for new, expanded roles and improved collaboration with improved outcomes for patients, particularly for people with complex long-term health conditions (Baileff, 2000).

This dissertation explores four practice nurses' perceptions of opportunities and barriers to the expansion of nursing roles within contemporary general practice using a qualitative descriptive methodology; a methodology used when insight into particular situations, social settings and relationships is required.

Purposive sampling was used to identify the participants for the study. This method is used when participants are chosen for their knowledge and experience of the phenomenon to be explored. Four practice nurses participated in the study. The nurses work in four different general practices within the same Primary Health Organisation. They all work and live in a rural area of New Zealand and all four identify as European / New Zealanders. The amount of time they have worked in general practice ranges from nine to twenty years. Three of the nurses have undertaken post-graduate study, two achieving a post-graduate certificate and one achieving a post-graduate diploma. The closest tertiary provider of post-graduate courses is a minimum of four hours travelling distance from the nurses' homes.

The four nurses were interviewed individually, each interview was tape-recorded and the tape recordings were transcribed by an independent person. The data were analysed using thematic analysis. Following coding of the interview narratives two main themes emerged: 1) further education is required before practice nursing roles can be expanded and 2) nurses who work in expanded roles experience enhanced professional self-esteem.

Recommendations for further research and development include scoping enhanced and diversified learning methods for nurses who live and work in rural areas and; providing more 'on-site' clinical and academic support, mentoring and networking to practice nurses working in general practice in rural areas.

Consideration should also be given to integrating practice nurse 'short courses' (e.g. vaccination and smear training) into post-graduate study as part of a Postgraduate Certificate in Primary Health Care Nursing. Blending 'hands on' courses with the theoretical underpinning of advanced study could attract more practice nurses into a post-graduate pathway of education, essential if practice nurses are to work in expanded, autonomous roles.

KEY TO TRANSCRIPTS

The participants in this study were interviewed once, and each chose a pseudonym to protect their identity and ensure confidentiality.

Within the dissertation, whenever the participant's words and experiences are used, they are written in italics (*italics*), indented and referenced using their pseudonym. When the text has been edited to remove words (without changing meaning) a series of three full-stops is used (...).

KEY TERMS USED

Expanded practice:

Expanded practice occurs when a nurse assumes responsibility for a health care activity or role which is currently outside their scope of practice. Expanded practice may include areas of practice that have not previously been in the nursing realm or have been the responsibility of other health professionals (NCNZ, 2010a).

He Korowai Oranga: The Māori Health Strategy, 2002:

He Korowai Oranga sets the direction for Māori development in the health and disability sector. It is a strategic tool for these and other government sector to enable working together with iwi, Māori providers and Māori communities and whānau. The aim is to increase the life span of Māori, improve their health and quality of life, and reduce disparities with other New Zealanders (MOH, 2002).

Integrated Family Health Centre (IFHC):

An Integrated Family Health Centre is a facility to support a new way of working in a patient centered model of care. The centers are part of the national drive to deliver ‘better, sooner, more convenient health care’ by bringing together a range of health services and professionals. District Health Boards are required to support developments by devolving some secondary services to primary care settings. Promoting clinical leadership to facilitate the change is required to improve patient care and prevent disease (National Party, 2008).

New Zealand Health Strategy, 2000:

The New Zealand Health Strategy is required by legislation to set the direction for the national health system. It signals a focus on primary health care as central to improving the health of New Zealanders. Its principles prioritized reducing inequalities in health; improving access to health care, particularly for Māori, Pacific peoples and people from lower socio-economic groups; collaboration by all sectors; involving consumers of health care in decision-making; and acknowledging the special relationship between Māori and the Crown (MOH, 2000).

Nursing Integration Leaders:

Nursing Integration Leader roles were established in 2003. The role was conceived in response to a call to support the development of innovative models of primary health care nursing as part of implementing the Primary Health Care Strategy. The Nursing Integration Leadership roles are one of 11 innovations in New Zealand, chosen by the Ministry of Health, to develop primary health care nursing. Being an integral part of local Primary Health Organizations (PHOs) from the outset the roles have been closely aligned to the development and operation of PHOs and primary health care nursing since 2003 (MOH, 2007).

Practice Nursing:

Practice nursing is a specialty within primary health care nursing. Practice nurses are registered nurses who work within general practice, providing a comprehensive range of first contact primary health care services to an enrolled patient population (MOH, 2003a). Within the dissertation primary health care nurses working in general practice are referred to as practice nurses.

Primary Health Organisations (PHOs):

Primary Health Organisations are not-for-profit entities funded on a capitation basis to provide essential services to their enrolled populations. In addition to general practitioners and practice nurses providing first-line and preventative services, PHOs implement health promotion programmes and offer a range of other health services including dietitians, psychologists and pharmacists. PHOs include both the community and health providers in their governance structure (MOH, 2001).

Primary Health Care Strategy (The Strategy), 2001:

The Primary Health Care Strategy was launched in 2001 following the New Zealand Health Strategy and the New Zealand Disability Strategy. It signaled a new direction for primary health care with a greater emphasis on population health and the role of the community, health promotion and preventative care. It highlighted the need to involve a wide range of

health professionals outside the traditional confines of general practice, with patient funding based on population needs rather than fees for service. The Primary Health Care Strategy identified primary health care nurses as crucial to its successful implementation (MOH, 2001). Within the dissertation the Primary Health Care Strategy is referred to as ‘The Strategy’.

Primary Health Care Nurses:

Primary Health Care Nurses work in a wide range of roles in a variety of settings including homes, schools, general practices, clinics, marae and workplaces. Primary Health Care Nurses are registered nurses with knowledge and expertise in primary health care practice; they work collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan (MOH, 2003a). Within the dissertation primary health care nurses working within general practice are referred to as practice nurses.

Whānau Ora, 2010:

Whānau Ora is an evidence-based framework that aims to strengthen Māori whānau (family) capabilities, and wellbeing. In 2009 the New Zealand government approved the establishment of the Whānau Ora Taskforce; following their recommendations Whānau Ora collectives were formed in 2010. Through Whānau Ora collectives relationships are created between government and community agencies which are broader than current contractual relationships. Embedded within Whānau Ora philosophy are aspirational goals which focus on social, economic, cultural and collective benefits for Māori (Durie, Cooper, Grennell, Snively & Tuaine, 2009).

LIST OF FIGURES

Figure 1: Themes, sub-themes and codes

LIST OF TABLES

Table 1:	Fee for service model contributing to health disparities.....	7
Table 2:	Cited challenges to the successful implementation of the Primary Health Care Strategy.....	16
Table 3:	Identified barriers to the expansion of the nurse role in General Practice.....	16
Table 4:	The Whare Tapa Wha model: the four cornerstones of Maori identity.....	19
Table 5:	Whanau Ora Outcome Goals.....	20
Table 6:	Components of a successful team.....	24
Table 7:	Components of patient care which enhances the patient / doctor relationship	30
Table 8:	Issues affecting the capacity of practice nurses to work in expanded role..	31
Table 9:	Profile of the practice nurse workforce, 2010.....	32
Table 10:	Comparison of hourly pay rates for practice nurse and Registered Nurse employed by DHB.....	33
Table 11:	Four major themes of nurses' views on empowerment.....	35
Table 12:	Phases of thematic analysis.....	47

CHAPTER 1: INTRODUCTION

Introducing the Author

I am a nurse leader working within a primary health organization in a predominantly urban area in New Zealand (NZ). My role focuses on leading the development of primary health care nurses by providing professional nursing leadership, strategic direction and facilitating integration between nursing services. My nursing leadership role is one of eleven primary health care nursing innovations introduced at the time of establishing Primary Health Organisations (PHOs) in New Zealand in 2003 (MOH, 2007). My role emerged from the vision of the nurse leaders who were part of the foundational development of the Primary Health Care Strategy (2001).

Prior to the formation of PHOs the Minister of Health stated that nurses would play a crucial part in realizing the vision of the Primary Health Care Strategy (MOH, 2001). Extra resource would be required to achieve this and, subsequently, it was announced significant funding would be allocated to support primary health care nursing ‘innovations’ as part of realizing the vision. The innovation funding was to be used to develop new models of care, support postgraduate study scholarships and to support practice nurses by developing new nurse leadership roles (MOH, 2007).

Three Nursing Integration Leaders (NIL) were appointed within the newly formed PHOs in a district with a high Māori population, significant disease burden and challenges of geographical isolation. My role is as one of these NIL situated within a large urban / rural PHO where I have worked for eight years.

The Nursing Integration Leadership role has a clear mandate to realize the vision and intent of the Primary Health Care Strategy through strong nursing leadership; the key focus being to lead practice nurse development. The position has been sustained and well supported despite major restructuring of PHOs between 2009 and 2011. Following a review in 2011 the role has been mandated as a key leadership position within the District Health Board and PHO nursing leadership team. In September 2011 the Nursing Integration Leadership

position was renamed and elevated to a strategic nursing role; Associate Director of Nursing, Primary Health Care.

Over the past eight years I have explored, questioned and witnessed many opportunities and barriers which practice nurses face whilst endeavoring to expand their traditional role. I have listened to their stories, observed and been part of their struggle with constant change and increasing workloads. The struggles and successes of many of these nurses has compelled me to find out more about the phenomena, and to question why it is so challenging to improve and expand the practice nurse role. I realized I needed to seek answers by asking the nurses who work in general practice about their experiences. It is especially important that I deepen my understanding of practice nursing as my primary health care nursing experience previous to my current leadership role included public health and district nursing roles, but not practice nursing.

This research will help my understanding of both practice nursing and of the nurses who work in this role to enable me to influence future developments. This will assist to inform the change required to deliver 'better sooner, more convenient primary health care' (Ryall, 2007) within newly developing Integrated Family Health Centers in New Zealand.

Purpose of the study

As a primary health care nurse leader I have a clear purpose; to make a difference to the lives of people most in need, through the provision of focused nursing leadership. To achieve this vision I need to understand the complexities, opportunities and barriers that will enable improvement of the health of the population I serve. The purpose of this study, therefore, is to gain insights as to how the role of the practice nurse can be expanded to achieve improvement in patient health outcomes. In order to achieve this aspirational goal, and to lead change to make it happen, I need to identify and recognise opportunities and barriers to the expansion of the practice nurse role. I must firstly gain understanding of what the historical journey has been, and secondly, what the nurses current day-to-day reality looks like.

To gain understanding of the historical journey of practice nurses I firstly searched the relevant literature, exploring the background of the practice nurse role within the New Zealand and international context. This furthered my understanding of the social, political and professional influences that have helped shape the role that exists today.

To further achieve the purpose of the study and to understand the day-to-day reality of practice nurses, I used a qualitative descriptive research methodology. This enabled me to explore, through one-on-one interviews with the four nurses, how they viewed their current role. I asked five open ended questions to ascertain this.

1. What is your understanding of expanded nursing practice?
2. What are the opportunities to make this happen?
3. What are the barriers to implementing expanded nursing practice?
4. How can some of the identified barriers be overcome?
5. What professional development is required to support the development of expanded practice for practice nurses?

These questions sought to answer the research question; *What are practice nurses' perceptions of opportunities and barriers to the expansion of nursing roles within contemporary general practice?*

Two main themes emerged in response to the five open ended questions in each interview:

- 1) Further education is required before practice nursing roles can be expanded and;
- 2) Nurses who work in expanded roles experience enhanced professional self-esteem.

These emergent themes will be a useful guide to future developments for practice nurses working in the PHO where I work, especially with the drive to create integrated family health services. The findings from the dissertation will assist to guide the direction for me to lead and create opportunities for practice nurses to expand their roles that will in turn make a difference to the population we serve.

Background: History of Health & Practice Nurse Development in New Zealand

The Prime Minister of the first Labour Government of New Zealand, Michael Joseph Savage, introduced health reforms into New Zealand society; these reforms would have long-lasting and far-reaching influence on the health of the New Zealand people. From 1935 to 1949 the Savage-lead government introduced a myriad of social, economic and welfare policies; these included many health benefits to assist the population of New Zealand to achieve improved health (Sutch, 1941). Hospital care and public health services were, and still are, provided free of charge to all New Zealanders.

The radical reforms of the Labour government also included many population health initiatives such as free milk for children in schools and assistance with the provision of high quality state housing. Primary healthcare was made available through the public health system with the commencement of the first primary health care nursing services – the mobile district and public health nursing services, ensuring health services were delivered to remote communities. Primary care services involving visits to a general practice have always incurred a part-payment fee with the government ‘topping up’ the fee to enable affordable primary care, specifically for people on low incomes (Sutch, 1941).

In the 1970’s international attention was being focused on primary health care development as a tool for reducing health inequalities. The signing of the Alma-Ata Declaration at an international conference in 1978 was a universal, public declaration and commitment to work together to achieve health for all (Declaration of Alma Ata, 1978). Following this the NZ Department of Health led the concept of aligning health with culture. In 1992, under the leadership of the then Director-General of Health, Dr George Salmond, the government accepted and integrated the principles of the 1840 Treaty of Waitangi into health service policy in New Zealand (Sheridan, Finlayson & Jones, 2009).

In 1970, in line with international thinking about maximizing primary health care, the New Zealand Government Practice Nurse Subsidy Scheme (PNSS) was introduced. At this time the PNSS was the NZ government’s commitment to support general practice’s to employ registered nurses to provide assistance to the general practitioner. Prior to this the number of nurses working in general practice was small with nurses acting as receptionists or

doctor assistants (Brown, 1992, cited in Henty, 2005). A later review found that there was a significant increase in the number of practice nurses employed by general practitioners following the introduction of the PNSS (Michel, 1997, cited in Cumming et al, 2005).

The intent of the subsidy was to enable nurses to assist the doctor but also to address areas of patient need (Docherty, 1996; Docherty, Sheridan & Kenealy, 2008). With the PNSS payment being made directly to the general practitioner, and with no external monitoring or control, the reality of the early practice nurse role was that it was often used in wide and varied ways. Non-nursing work with no direct patient care was common, with registered nurses providing support to the general practice as receptionists and administrators (Brown, 1992).

In 1974 the PNSS was reviewed by the New Zealand Department of Health and was placed under regulatory authority, overseen by the Principal Public Health Nurse. This allowed endorsement of the practice nurse role that embraced nurse-related work and professional responsibility within the general practice environment. It also heralded the possibility of a newly supported and empowered workforce of nurses working within general practice (Docherty, 1996).

However, unlike their contemporary practice nurse colleagues in Great Britain during the 1980's, practice nurses in New Zealand did not pursue, and were not supported to acquire, a recognized career pathway to a degree level qualification supported by a national framework. In spite of substantial amounts of publically funded financial support being provided to private general practice businesses, through the PNSS, it did nothing to advance the role or professional status of practice nurses (Docherty et al, 2008). This supports the finding of a review in 1997 that showed little evidence of any substantive health benefits to the population following the introduction of the PNSS (Michel, 1997 cited in Cumming et al, 2005). The 2001/2002 NZ National Medical Survey also confirmed that practice nurses were not working in expanded roles. They were under-utilising their range of skills, had limited graduate or postgraduate qualifications, and there was a paucity of Maori and Pacific nurses working in primary care (Kent, Horsborough, Lay-Yee, Davis & Pearson, 2005).

By the 1990s new guidelines were introduced for the PNSS. These guidelines reflected the climate of the era of primary health care described as, fragmented and market-driven with a focus on individualistic treatment that were ‘doctor driven’ (Carrier, Digman, Horsburgh, Hughes & Martin, 1999). Issues for practice nurses at this time included role ambiguity, confusion about accountability, and power / authority differentials. Docherty et al (2008) assert this was the critical point at which practice nursing became severely compromised. There was no clear funding mechanism to support the necessary change to enable practice nursing to become a rich, robust career choice with a supported career pathway. Māori health continued to decline with growing awareness that primary care was not meeting the needs of Māori patients.

With primary health care the province of private practitioners with a ‘one-size-fits-all’ approach there was a very limited regard or understanding of cultural diversity and perspectives. To address this, in the 1990s, some devolution of health funding occurred allowing more contestability for funding. The emergence of Māori / Iwi health provider organizations gave opportunity for Māori to access culturally appropriate health and social services with a more holistic whānau approach (Durie et al, 2009).

During this era the long standing primary care system for GP visits was coming under close scrutiny with the government’s subsidized approach known as ‘fee-for-service’ under the spotlight. Along with patients paying unregulated fees, the fee-for-service model was cause for contentious debate due to several identified anomalies affecting patient access to primary care services. It was widely recognized, the fee-for-service model contributed to health disparities (Cumming et al, 2005).

Table 1: Fee for service model contributing to health disparities

Poor access for some population groups arising from financial, cultural and other barriers
Little incentive for general practices to engage in health promotion / disease prevention
Poor / uneven distribution of primary care workforce
Inability to fund according to population health needs – funding was directed to high health users rather than to those people with the highest health need
GP domination with under-development of the wider primary health care team & service provision

Cumming, Raymont, Gribben, Horsburgh & Kent (2005)

A national survey of primary health care and community nurses conducted in 2001, prior to the release of the Primary Health Care Strategy, endorsed this belief identifying several key issues hindering practice nurse development. These include paucity of Māori and Pacific nurse leaders within general practice; lack of relief staff to allow release time for study and team / peer collaboration; and limited funding to enable the introduction of new nurse-led programmes (MOH, 2003b).

Since 2000 primary health care nursing has been significantly influenced by government policy of the day with several strategies focusing on primary health care development. Under a Labour-led coalition the NZ Health Strategy (2000) was launched, followed closely by the Primary Health Care Strategy (2001), and a year later He Korowai Oranga: the Māori Health Strategy (MOH, 2002). A change of government in 2008 committed to continuing to build on these strategies, with the National-led coalition government introducing the ‘better, sooner, more convenient’ model, followed by the Whanau Ora (2009) model of care.

‘Nursing Developments in Primary Health Care 2001-2007’ (Finlayson et al, 2009), is a key report outlining the development of primary health care nursing since the introduction of the Primary Health Care Strategy. The research was intended to ‘take the pulse’ of the primary health care sector, five years after the implementation of The Strategy. A total of 110 interviews were conducted with practice nurses, GPs, practice managers, board members and board chairs in 2006. The report identified areas requiring future priority for developing primary health care nursing; funding, education, leadership, mentoring, governance, recruitment and retention (Finlayson et al, 2009).

The report identified key themes necessary to achieve priorities in relation to primary health care nursing; collaboration, capability, and capacity. These themes are used in the dissertation to guide the literature review, and identify the underpinning theoretical framework of the dissertation; critical social theory.

Collaboration

A collaborative approach to team work is required by members of the primary health care team if access to services is to improve. Practice nurses see teamwork as incorporating complementary practice, equality and working together for the greater good of the patient. Practice nurses need to drive the quest for improved team-work both from within and beyond the confines of the general practice environment, ensuring patients have access to a wide range of skills from the extended multi-disciplinary team. Leading collaborative team work requires focused nurse leadership and a strong sense of professional self-esteem.

Capability

Increasing the capability of primary health care nurses is essential to ensure health improvements. Capability includes improving skills, broadening experience, enhancing education and qualification opportunities, improving autonomy in expanded roles, developing new models of care, and integrating culturally based practices and relationships. Capability also means encouraging nurses to ‘step up’ to take on more autonomous roles, to value themselves and their role, and to lead the change required to provide equitable care to their enrolled population in an increasingly complex and demanding environment.

Capacity

Increasing capacity of the primary health care workforce by improving size and demographic spread of the workforce is essential. Workforce capacity issues are not solely about the number of people working in health; equity, cultural appropriateness, skill mix and empowerment are other important considerations. Inequitable pay rates, variable employment conditions and culturally unsafe work environments all influence nurses’ views of their roles and their choice of work environments.

Critical social theory

Empowerment is an important concept for both nurses and the nursing profession. The notion of nurses being a disempowered group is explored within the dissertation. A summary is given in the final part of chapter 2, where the theoretical framework of critical social theory in relation to the literature review is summarised.

Context of this study

Whilst my nursing practice is located in a predominantly urban area, the enrolled population of the PHO served by the research participants is a significant rural population, with its accompanying isolation. Isolation, both geographical and professional, has an impact on autonomous practice of nurses in all areas of the district where I work, both urban and rural. A large Māori population, transport difficulties, high deprivation, distance from tertiary health and education services, and workforce issues of recruitment, retention with an ongoing paucity of locum/relief staff all contribute to professional challenges when accessing higher education to achieve expanded roles of practice.

Significance of the study

Local and international evidence supports the expanded role of nurses in primary healthcare, particularly in the management of long-term conditions. It further suggests the expanded nursing role enhances and complements the role of the general practitioner, particularly when located in high deprivation areas, where nurses can provide critical safety nets for under-served populations (Torrison & Hansen-Turton, 2005).

This dissertation identifies some of the opportunities and barriers which need to be addressed to enable both a 'new way of working' and to expand existing nurse roles in primary health care. The research has enabled the author to gain deeper understanding of some of the issues faced by practice nurses. With deeper understanding it is hoped some of the challenges will be addressed in my new role as the Associate Director of Nursing, Primary Health Care.

Structure of the dissertation

The dissertation is presented in five chapters as follows:

Chapter One provides an introduction to the author of the dissertation and sets out the purpose of the study; to gain deeper understanding and to explore the opportunities and barriers to expanding practice nursing roles. A history of health and practice nurse development in New Zealand is provided to ‘set the scene’ for the dissertation. The context of the dissertation is briefly given, followed by a summary of the significance of the research.

Chapter Two provides a review of the literature pertaining to significant milestone developments within the health sector in New Zealand from 2000 to 2010. The Primary Health Care Strategy (2001), and Whanau Ora (Durie et al, 2009), are discussed in relation to primary health care nursing using key themes from a survey conducted in 2006; Nursing Developments in Primary Health Care 2001 – 2007 (Finlayson et al, 2009). The themes are collaboration, capability and capacity. A summary of the literature review is given using critical social theory as a theoretical focus.

Chapter Three discusses the research design and methodology used for the dissertation. An outline of the qualitative descriptive methodology is given along with ethical considerations. The participant selection process, purposive sampling, is outlined and the consent process recorded. The interview process, followed by the data analysis using thematic analysis is explained, along with identification of key themes and the process of how these themes emerged. A conclusion outlining the challenges and highlights of the research methodology summarizes the chapter.

Chapter Four outlines the research findings, the four participants’ experiences and perspectives are given in transcribed narratives. The result of the data analysis is given with two main themes emerging from the findings;

- 1) Further education is required before practice nursing roles can be expanded and;
- 2) Nurses who work in expanded roles experience enhanced professional self-esteem.

The themes are discussed under the sub-headings; Opportunities and Barriers; Depth of Understanding; Being Valued; Autonomy and Leadership.

Chapter Five offers discussion of the research findings, implications for future clinical practice and suggests some direction for practice nurse development. It outlines and recognises the study's limitations due to the small number of participants involved; and explores potential suggestions and implications for further research.

Conclusion

Practice nursing is an important and crucial part of primary health care service delivery. The practice nurse role has been part of the New Zealand healthcare system for over sixty years and has survived several government policy changes. All of the changes have affected how the role is funded, the level of support given to further education, pay rates and work conditions. Some of these policy changes have been positive and beneficial and some have created barriers to enhancing the role.

To understand the current context of the practice nurse role the following chapter reviews the literature.

CHAPTER 2: LITERATURE REVIEW

Introduction

The New Zealand government's plan for 'better sooner, more convenient primary health care' (Ryall, 2007) has a clear mandate; to improve access to services, devolve treatment from secondary to primary services, be patient-centered, be led by clinicians, be cost-effective and deliver on health targets. What is unclear is how this will be achieved in practice, and how the proposed new primary care service model will partner with Whānau Ora to address disparities that exist in the current medicalised model of healthcare in Aotearoa/New Zealand. With the increasing burden of chronic disease it is essential to clearly articulate, strategise and plan how the new model will be different to the current one and how this will impact on primary health care nursing.

The present New Zealand health care system has its origins in the foundation objectives and principles of the Public Health and Disability Sector Act, 2000. The Act radically altered a change of direction for healthcare, shifting the focus from personal health to population health, and strengthening local community input into decision making. As a result of the Act, several strategies were conceived setting the direction for primary health care in New Zealand (Skegg & Patterson, 2006).

At the beginning of the new millennium the New Zealand Health Strategy (MOH, 2000) set out the overall direction for health in Aotearoa / New Zealand. He Korowai Oranga: Māori Health Strategy (MOH, 2002), further expanded on the principles and objectives for improving Māori health. It identified the need to maximize health and wellbeing for Māori through the concept of whanau ora; supporting Māori families to achieve their maximum health and wellbeing by supporting the four cornerstones of whānau / family health; taha wairua (spiritual); taha tinana (physical); taha whānau (family) and tino hinengaro (mental health) (Durie, 1998).

He Korowai Oranga: Māori Health Strategy, has four clear pathways to move this vision towards the reality of improved Māori health. 1) Whanau, Hapu, Iwi and community development; 2) Māori participation; 3) effective service delivery; 4) working across

sectors. He Korowai Oranga: Māori Health Strategy considers the broader concepts of Māori living in contemporary New Zealand. It challenges the constraints of individualistic health service delivery, the model primarily adopted in general practice, and recognises that Māori want to actively direct and shape their future. Fundamental to He Korowai Oranga is the Government's commitment to fulfilling the special relationships between Iwi and the Crown under the Treaty of Waitangi; the principles of partnership, participation and protection underpinning the relationship; a concept based on integration and signed in good faith in 1840 (MOH, 2002).

The Primary Health Care Strategy

The Primary Health Care Strategy (2001) preceded He Korowai Oranga: Māori Health Strategy by one year, signaling to the health provider sector, specifically the primary health care sector, the importance of a collective and shared vision to reduce inequalities in health.

The Labour-led coalition government, 1999 to 2008, was committed to the development of primary health care in New Zealand investing \$1.7 billion into the sector over six years (Cumming et al, 2005). The Primary Health Care Strategy (2001), hence-forth known as The Strategy, along with the introduction of Primary Health Organisations (PHOs), provided a new direction for primary health care in New Zealand. It set the course for, arguably, the most radical shift in thinking within health care since the Michael Savage reforms of the 1930s.

With the inception of the PHOs came a shift from patient fee-for-service payments to population funding, known as Capitation. This was expected to both lower fees for patients and create opportunities for improved team work, an aspect of which was the development and expansion of the role of nurses working in primary care settings (Ashton, 2009; Cumming et al, 2005). The Minister of Health gave a clear message of expectation that PHOs would reach beyond the traditional confines of general practice; broadening and extending services to include the wider health team, therefore enabling access to a wide range of health professionals not traditionally linked to general practice (Finlayson et al, 2009).

Explicit in statements of the time was the message nurses would play a crucial part in realizing the vision of The Strategy, and that the implications for nurses working in primary care were significant. Funding of \$8.1 million over five years to support primary health care nursing development was announced by the Minister of Health. The funding was to develop innovative new models of care, and support postgraduate study scholarships for primary health care nurses. The development of rural nurse practitioners was also identified as a key priority (Ashton, 2009).

The Strategy had a clear mandate for nurses to be involved with addressing health inequalities, creating opportunities for improving patients' access to services, addressing population health issues, and developing new ways of working to ensure effective delivery of health services. Significantly The Strategy also signaled a national strategic move to develop and grow a workforce of well trained nurses working in primary care (MOH, 2001).

At the time of launching The Strategy there was a sense of renewed optimism for the potential to support and grow the practice nurse workforce; a workforce that had previously struggled to achieve recognition, autonomy and clinical specialty status (Docherty, Sheridan & Kenealy, 2008). Shifting from fee-for-service payments to Capitation was expected to lower fees for patients creating opportunities for improved team work, an aspect of which was the development and expansion of the role of practice nurses (Ashton, 2009; Cumming et al, 2005). It was implicit within The Strategy that if progress and improvement to the health status for New Zealanders was to be achieved, nurses working in primary health care needed support to achieve the priority goals. Nurses needed to have strong clinical leadership. They needed to be well educated within a career framework, working in expanded roles with greater responsibility and accountability. They needed to be; more 'population focused' rather than individual focussed; proactive to health need rather than reactive; an integral part of an inter-professional, multi-disciplinary team; and provide services targeted to populations with the greatest need (Clendon, 2010; Cumming et al, 2005; Finlayson et al, 2009; MOH, 2001).

Changing roles within primary health care at this time signaled more opportunity for practice nurses. But the on-going theme of medical dominance and nurse disempowerment prevailed, highlighting inequality of power and status relationships between GPs and practice nurses, and, for some, difficult team working relationships. Structural arrangements, attitudes and differing philosophy remained key issues (Davis, 2005).

Reporting on developments in primary health care between 2003 and 2004, following the launch of The Strategy, Cumming et al (2005) found a wide and variable picture of nursing opportunities embraced by practice nurses within the traditional general practice context. Expanded practice was largely dependent on the personal view of GPs as employers, and their workload. The higher the workload the more likely the GP was to assign tasks to the practice nurse rather than supporting the expansion of an autonomous nursing role. Other barriers to expanding nursing practice included; the status of the employer / employee relationship with GPs and practice nurses; preference by some health professionals for the traditional hierarchical employment structure; reluctance of patients to accept nurses as the first point of contact; and a significant barrier, the lack of an identified, protected nurse funding stream within the newly implemented population-based funding formula, perpetuating the power and status differential between practice nurses and GPs (Ashton, 2009; Cumming et al, 2005; Finlayson et al, 2009).

The Strategy has remained under public scrutiny since its inception, but at no time more intensely than the lead up to the 2008 New Zealand government elections. In a health discussion paper by the National Party spokesman, prior to the elections, several aspects of the delivery on the objectives of The Strategy were challenged (see Table 2). The incumbent Health Minister cited failure on several counts, including the lack of expansion and involvement of the nursing role in primary care (Hodgson, 2006).

Table 2: Cited challenges to the successful implementation of the Primary Health Care Strategy.

Failure to deliver quality improvements offered by multi-disciplinary teams
Failure to deliver a broader, wider range of health services in a primary setting
Failure to build a strong and expanded involvement of nurses in primary care
Slower than expected progress of integrated working between primary and secondary services

Hodgson (2006)

The centre-right National-led coalition government, formed in 2008, pledged continued support for furthering the intent of The Strategy and addressing the failings. Their mandate was a focus on ‘better, sooner, more convenient’ health care for the New Zealand population by devolving hospital-based services into primary care, and developing integrated health centers (Ministerial Review Group, 2009; Ryall, 2007). The changes implied an expanded future role for primary health care nurses (Ashton, 2009).

Following the initial progress report on developments since the launch of The Strategy by Cumming et al (2005), a second report focused specifically on developments of primary health care nursing. Reviewing nursing developments in primary care over the period 2001 to 2007, after the development of The Strategy, several key barriers to the expansion of the nursing role were identified (Finlayson et al, 2009).

Table 3: Identified barriers to the expansion of the nurse role in general practice.

The employer – employee relationship between practice nurses and general practitioners
GPs attitudes including lack of support and motivation from GPs
Current funding structures
Poor remuneration
Lack of leadership
Lack of educational opportunities
Lack of physical resources
Not being recognized as autonomous health professionals by patients

Finlayson, Sheridan and Cumming (2009)

As well as these identified barriers some doctors reported feeling anxious about or suspicious of nurses “taking over their roles” (MOH, 2009, p.7). Other reports have identified similar barriers to the expansion of the practice nursing role, with one barrier

being cited in several reports; the current funding structure linked with the employer-employee relationship between practice nurses and general practitioners (Ashton, 2009; Clendon, 2010; Cumming et al, 2005; MOH, 2009; Primary Health Care Advisory Council, 2009) causing stagnation of the role (Docherty et al, 2008).

It was further reported by the Primary Health Care Advisory Council (PHCAC), an official working group set-up to provide advice on primary health care service models to the Ministry of Health and District Health Boards, that the private business model of most general practices in New Zealand significantly hampers the development of other roles within the primary health team. The PHCAC working group identified an imbalance of power due to the funding being held by one group. The private business model was again viewed as a barrier to developing good teamwork and inhibiting the expansion of nursing roles. It was stated that a private business model, as well as creating power differential, may not support the protected time required to develop and maintain teamwork due to the perception that meetings and team building exercises are not productive use of time (PHCAC, 2009).

The chairperson of the New Zealand Medical Association (NZMA) General Practitioner Council, while articulating his professional body's support for the advancement of the practice nurse role, challenged assertions that the role has stagnated due to practice nurses remaining employees of GPs. In an editorial in the New Zealand Medical Journal the NZMA chairperson states:

“Team-work and clinical governance are much more important than whether funding is ‘ring fenced’ for nursing or what the employment arrangements of practice nurses (and GPs) are” (Peterson, 2008, p.3).

National and international evidence, however, supports the notion that there is plenty of work for everyone. The expanded role of nurses is argued to enhance- and complement, rather than usurp, the role of the general practitioner, and at the same time brings considerable revenue into the practice through nursing specific services, such as immunisation, chronic care management and population screening programmes (Hefford et al, 2010). The worth of nurses is clearly identified when located in high deprivation areas

where nurses can provide critical safety nets for under-served populations providing programmes that are targeted to meet people with the highest unmet need (Torrison & Hansen-Turton, 2005).

The Strategy is explicit with its intent to ensure people have affordable access to culturally appropriate health care. Ten years following the launch of The Strategy the evidence suggests this vision has yet to be fully realized with Māori continuing to have the poorest health status of any ethnic group in Aotearoa / New Zealand (Jansen, 2008; MOH, 2006). In response to this the Whānau Ora framework, a cultural approach to addressing health disparities, became government policy in 2009. This was to ensure Māori are supported to access quality primary care services which are responsive to need, and are culturally appropriate (Durie et al, 2009).

Māori Health: Whānau Ora

Whānau Ora is an evidence-based framework that aims to strengthen whānau capabilities and wellbeing. In 2009 the New Zealand government approved the establishment of the Whānau Ora Taskforce, chaired by Professor Sir Mason Durie. Following extensive consultation with urban and rural whānau, hapu, iwi and service providers, in 2010 Whānau Ora collectives were formed. Through Whānau Ora, collaborative relationships are created between government and community agencies which are broader than current contractual relationships and, through agreed outcome goals, aim to be more cost effective. Embedded within Whānau Ora philosophy are aspirational goals that focus on social, economic, cultural and collective benefits for Māori (Durie et al, 2009).

Māori have greater burden of illness in Aotearoa / New Zealand compared to non-Māori (MOH, 2006). It is well documented that the burden of disease is greatest in areas where primary care providers have the most influence; diabetes, smoking related lung diseases, cancers, heart disease and avoidable hospital admissions (Jansen, 2008; Ministry of Health, 2002). Evidence suggests that Māori patients' experiences when accessing primary care are sub-optimal. A multi-phase study in 2001/2002 reported; Māori being less likely to be seen on time in general practice; doctors reporting lower levels of rapport with Māori patients;

and Māori being less likely to be offered choices of appointment times at their general practice compared to non-Māori (Crengle et al, 2005). Jansen (2008) attributes this to a health system that provides care which emphasises and values individualism and self-advocacy over and above the more ‘holistic’ contemporary Māori view of health, as is implicit within the Whare Tapa Wha model of healthcare (Durie, 1998), the principles of which are the foundation of the Whānau Ora framework launched in 2010 (Durie et al, 2009) and are listed in table 4.

Table 4: The Whare Tapa Wha model: the four cornerstones of Māori identity

taha wairua - spiritual dimension
taha tinana - physical dimension
taha whanau - family health
taha hinengaro - mental health

Durie (1998)

Whānau Ora is described as “Māori families supported to achieve their maximum health and wellbeing”, (MOH, 2007 p.1). Implicit within the Whānau Ora framework of family wellbeing is the important concept of honour; the need for Māori to uphold the honour of the whānau (Campbell, Gillett & Jones, 2005). Establishing a trusting relationship between the person providing healthcare, and the Māori patient and his/her family, is a crucial component of enabling and achieving improved health outcomes.

Eight years following the Primary Health Care Strategy and following extensive consultation by a select taskforce with Māori throughout Aotearoa / New Zealand, in 2009 the Whānau Ora framework became imbedded into Government policy (Durie et al, 2009). This signaled a change of how primary health care is delivered within communities. The framework has explicit goals that set the direction for measuring the success of improvement of Māori health, through the implementation of Whānau Ora outcome goals, outlined in table 5.

Table 5: Whānau Ora Outcome Goals

The goals will be met when whānau are:
• Self-managing
• Living healthy lifestyles
• Participating fully in society
• Confidently participating in te ao Maori
• Economically secure and successfully involved in wealth creation
• Cohesive, resilient and nurturing

Whānau Ora: Report on the Taskforce on Whānau Centred Initiatives (2009, p.7)

Within the framework is recognition of the variables inherent across sectors. This requires a more collaborative approach and an increase in capability and capacity of the primary care workforce if gains are to be made in economic, social, health and cultural aspects for Māori (Durie et al, 2009).

Improving Māori health outcomes requires a whole systems and team approach. It is an integral part of nursing ethics; the principles of human rights and equity. The International Council of Nurses Code of Ethics states:

“Inherent in nursing is the respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect.” (International Council of Nurses, 2006, p.1).

Collaboration, capability, capacity

A national survey ‘Nursing Developments in Primary Health Care 2001-2007’ outlines the development of primary health care nursing since the introduction of The Strategy. Three key themes capture the areas of nursing development necessary to achieve the vision of The Strategy; collaboration, capability, and capacity (Finlayson et al, 2009).

Collaboration

Finlayson et al (2009) identify collaborative teamwork as fundamental to improving access to health services, ensuring nursing developments progress. Practice nurses need to drive the quest for improved team-work, both from within and beyond the confines of the general practice environment, ensuring patients have access to a wide range of skills from the

extended multi-disciplinary team. Leading collaborative team work requires focused nurse leadership and a strong sense of professional self-esteem.

Teamwork is referred to by a number of different names in the literature with some papers referring to multidisciplinary, interdisciplinary, or inter-professional teams, and others referring to teamwork as an 'integrated way of working' (Carryer, 2009; NCNZ, 2007; PHCAC, 2009). For the purposes of this dissertation the term 'collaborative teamwork' will be used.

As MacIntosh & McCormack (2001) describe, well functioning general practice teams are teams that work in a partnership model with collaboration the essence of effective service delivery. Everyone in the team is important and has a role to play. A definition of a team is generally considered two or more individuals who have specific roles, perform interdependent tasks, are adaptable, and share a common goal (Salas, Dickinson & Converse, 1992). Teamwork is essential to ensure skill-mix and appropriateness of care meets the need of people presenting with diverse and complex conditions. Nursing, allied health services, community outreach services and providers of social services need to work alongside medical practitioners as part of a collaborative health team if health outcomes are to improve (MOH, 2001).

Collaborative teamwork is fundamental to current government policy with its drive to deliver 'better, sooner, more convenient' healthcare to New Zealanders. Both local and international focus is on shifting healthcare from secondary-based hospital services to community-based settings, with a progressive move to concentrate community-based general practices into larger facilities known in NZ as Integrated Family Health Centers (Imison, Naylor & Maybin, 2008; Ministerial Review Group, 2009; Ryall, 2007). This change requires, more than ever, a collaborative effort with teams working together for the greater good with strong clinical leadership.

A recently released report from England (The Kings Fund, 2011), reinforces this concept. Changes are forcing, not just shifts of thinking about geographical location of where healthcare is delivered, but they are also forcing a shift of thinking about existing roles,

philosophy, parameters of care and what collaborative teamwork really means. The role of the general practitioner as clinical leader is identified as being crucial if changes are to progress.

While it is well recognised there is an increasing demand for acute and primary health services in New Zealand, there remain many barriers to the development of new or expanded roles, especially within nursing. Co-location of multi-disciplinary health teams presents opportunities for improved collaboration, and therefore, improved outcomes for patients, particularly for people with long-term conditions (Baileff, 2000). Effective teamwork is essential if Integrated Family Health Centers are to be successful, but experiences from existing models of care demonstrate that it is unwise to presume teamwork exists just because people are working in the same building. In a recent New Zealand study of general practitioners and practice nurses (MOH, 2009), it was consistently reported that practices operated as a team. However, an external study by Schoen, Osborn & Trang Huynh (2006) found New Zealand general practice teams demonstrated low levels of collaborative teamwork, citing patch protection and attitude issues between GPs, nurses and other professionals as detractors to teamwork.

Imison et al (2008) claim that the reality is opportunities for real teamwork are often lost in general practice because of poor leadership, unclear lines of accountability and lack of robust governance structures. Principles of collaborative teams are often philosophically embraced by health practitioners but in practice integrated working does not happen. Co-location on its own is not sufficient impetus to motivate improved working between different professionals and different teams. Team building requires commitment, time and strong leadership (Imison et al, 2008; Imison, 2009).

In a discussion document 'Making a Difference' (Department of Health, 2000) the vision for what collaborative teams would achieve was reported. Collaborative teams would make a wider, more flexible set of skills available to enrolled populations, be responsive to patient's needs and not be driven by professional need. The discussion document also emphasised the need not to lose the individual identity of the professionals who make up the team, maintaining defined and recognized traditional roles were important to ensure

confidence for the general public. Earlier work by Black & Hagel (1996), explored the development of integrated nursing teams, identifying an essential component of a well functioning team is having clearly defined roles. Role clarity prevented confusion by both health professionals and the consumers accessing health services.

Teamwork does not automatically work just because people are in the same building. Recent evaluation of Polyclinics in the United Kingdom (Imison et al, 2008) concluded that “bringing staff together in one place does not necessarily change the way in which they work, and indeed can actually make joint working more difficult” (page x). Lack of both managerial and clinical leadership is cited as key reasons for lack of teamwork that has inhibited change and stalled new ways of operating. A ‘top down’ model and ‘one size fits all’ approach has also been identified as contributing to costly and underperforming polyclinics (de Montalk, 2010), with teams of practitioners continuing to work in the same way they have always worked, under one roof, but remaining in silos with little collaboration.

The principles for successful team-working are well documented but, as Imison (2009) observes, effective team-working is hard to achieve in practice. Larson & LaFasto (1989) cited in Imison (2009) identify eight key components to a successful team (Table 6).

Table 6: Components of a successful team.

An elevating goal
Effective team structure
Competent team members
Unified team commitment
Mutual trust
High standards for team performance
External support and recognition
Effective team leadership

Larson & LaFasto (1989)

Early models of Polyclinics in the United Kingdom had some or all of these components missing from their teams, resulting in low morale and staff burn-out. Imison (2009) concludes the reason for this is that each shift in service, or change in direction, has been guided by an administrative shift rather than being clinically driven; driven to save costs, largely disconnected and unrelated to patient need, and with scant recognition of what health staff actually do.

The value of building on existing good relationships between sectors as a fundamental driver for changing the way teams work and implementing new models is well supported in recent literature. Freeman & Peck (2007) suggest that functional, sound existing relationships between health providers are essential if organizational and cultural changes are to be made. Good relationships are a core component of all teams. A previous history of good working relations is one main factor in successful models of team-working; along with strong leadership, a values-based approach and sound investment in both process and structure (Colclough, 2008).

Building collaborative teams of primary care providers relies on process as much as structure. A key action to achieve this is to ensure significant input is obtained from the key drivers of the change. Imison (2009) suggests a successful model of integrated and collaborative care requires a significant input from one particular group of primary health care professionals, the general practitioners. In the United Kingdom, Klein (2006), noted a key inhibitor for lack of progress with the development of integrated teams within primary health centers has been due to opposition and antagonism by general practitioners led by

their professional bodies, the Royal College of General Practitioners (RCGP), and the British Medical Association (BMA).

Similarly, in New Zealand, the first report of the development of The Strategy identified attitudes of practice nurses' employers as being a major factor restricting the expansion of nursing practice within primary care (Cuming et al, 2005). As in the United Kingdom a new proposed primary health service model was not supported by the New Zealand Medical Association (NZMA) and the Royal New Zealand College of General Practitioners (RNZCGP). The rationale for their lack of support was the proposal had attributed insufficient importance to the role of the general practitioner in first contact care. The proposal primarily focused on patient centered care, issues of enabling access, and planning for future healthcare with limited general practitioner numbers necessitating the expansion of the role of nurses (PHCAC, 2009). Carryer (2009), asserts that our current leadership model of primary care continues to favour a medical model of care to the detriment of keeping patient's needs at the centre of decision-making.

In New Zealand current debate identifies the need to have much greater acknowledgement of the wide and varied range of practitioners and professions who contribute to primary health care teams along with their current scopes of practice and evolving roles. The Primary Health Care Advisory Council (2009) clearly identified, and named, the fundamental issue which currently inhibits integrated team work in New Zealand, stating issues around professional role boundaries are the biggest barrier to developing integrated, interdisciplinary teams. In a summary of the PHCAC's work to provide advice to the Ministry of Health and District Health Boards on proposed new Primary Health Care service models it was reported;

“...advice (to the Ministry of Health and District Health Boards) should explicitly highlight the tensions around the roles and workforce development pathways of Nurse Practitioners / other primary health care nurses and their relationship with general practitioners in the belief that these tensions are central to making progress on teamwork in primary health care.” (PHCAC, 2009, p.4)

Collaborative partnerships, working in multi-disciplinary teams, can deliver improved services to a wide range of people with diverse health needs, especially teams that reflect the demographics of the community served (Keleher & Murphy, 2004). In a recent review of literature of team based models of care, three distinct types of relationships within teams were identified; the co-active relationship, where one member of the team is dominant and delegates to others; the competitive relationship, where parties are competing for similar roles; and the interactive relationship, where shared responsibility and equality underpins collaboration (Hefford et al, 2010). The interactive model approach is the preferred option with collaboration and trust underpinning the working relationships, allowing health practitioners working in the traditional model of general practice to reach their full potential.

Capability

Increasing the capability of primary health care nurses is essential to ensure health improvements (Finlayson et al, 2009). Increased capability for practice nurses means improving skills, gaining broader experiences, enhancing education and qualification opportunities, developing new models of care, and integrating culturally based practices and relationships. Capability also means encouraging nurses to ‘step up’ to take on more autonomous roles, to value themselves and their role, and to lead the change required to provide equitable care to their enrolled population in an increasingly complex and demanding environment (Carryer, 2009; Finlayson et al, 2009; MOH, 2003a; MOH, 2009; MOH, 2010).

The role and capability of practice nurses is wide and varied with variances measured in reports and studies over the past decade. A 1999 cross sectional survey study of 149 practice nurses in New Zealand revealed the workforce had wide variance of skills and knowledge with low post-graduate qualification attainment, and a significant number of practice nurses not undertaking any on-going professional development (Lightfoot et al, 1999). A later study, commissioned by the Independent Practitioner’s Association of New Zealand, reported practice nurses spent, on average, 65% of their time on non-patient tasks (IPAC, 2002). In the same year, a UK study exploring the potential barriers to the expanded role of nurses in general practice teams, highlighted one major obstacle to the implementation of the expanded role; their GP colleagues feeling threatened. The GPs

expressed concern that nurses would have a lack of intelligence and training to perform the advanced role, and their presence would threaten the other registered nurses working in general practice (Wilson & Pearson, 2002).

At this time similar power differential issues were being faced in the New Zealand primary health care sector. A report to the Ministry of Health by the government appointed expert advisory group on primary care recommended several ways to address barriers to building capability. One recommendation, regarded as contentious, addressed the employer / employee relationship of the GP and practice nurse. The advisory group recommended a shift of the accountability for nursing services to nursing management within the newly forming PHOs. This was an attempt to align accountability for nurses' professional, educational and employment arrangements with primary health care nursing leadership, effectively moving practice nurses out of the private business model for the first time in New Zealand's history (MOH, 2003a). Eight years on PHOs are well established and the private business model of general practice remains with the majority of practice nurses, 64.2% still employed by GPs (NCNZ, 2010).

Finlayson et al (2009) clearly identify the need to increase the capability of nurses if the vision of The Strategy is to be realized. Capability includes skill, experience, qualifications and cultural competency. Carryer (2011) supports this and adds an essential requirement is for nurses to become willing and empowered to 'step up'. She observes a steady rise in collegiality and collaboration between nurses and physicians where nurses are more confident and clear about their autonomy and their clinical expertise. Carryer reported on feedback from doctors interviewed in several focus groups – the more doctors felt able to trust the nurse's capability, the more they were able to work collaboratively as a team.

Improving nurse capability has been supported through legislation. The introduction of the Health Practitioner Competence Assurance Act (2003), replacing the Nurses Act 1977, ensured nurses maintain knowledge and skills through the need to meet competence-based-practicing certification, requiring ongoing education and self / peer assessment (NCNZ, 2007). Some practice nurses are also participating in recognized Professional Development Recognition Programmes (PDRP). Opportunity for post-graduate education for practice

nurses has been enhanced by the availability of post-graduate funding from the Ministry of Health, through Health Workforce New Zealand (previously known as the Clinical Training Agency).

Take-up of post-graduate study by practice nurses is, however, relatively low compared to the rest of the sector. Fifty-eight per cent of all practicing registered nurses have at least one qualification gained after their initial registration compared to 40% of practice nurses (NCNZ, 2010b). Lack of release time and relief staff are cited as key reasons for practice nurses not maximising post-graduate study opportunities (MOH, 2003; MOH, 2010).

A recent report by Health Workforce NZ gives a very clear and prescriptive message of how to improve nursing capability within primary care. It states early engagement of new recruits into post-graduate study is the key, and should follow a minimum of two years experience in a primary care setting. The report states that “formal post-graduate sub-specialty education is crucial to the provision of optimal patient care delivered by a workforce with skills that match the complexity of demand” (p.39). Supporting new graduates into Nurse Entry to Practice Expansion (NETPE) programmes is another opportunity to assist and engage nurses with post-graduate study early in their career, providing both funding and mentorship (Health Workforce Information Programme, 2010).

Despite ongoing challenges the role of the practice nurse has changed since the introduction of The Strategy, with more opportunities for nurses within the PHO environment. With PHOs came extra funding sources with increased opportunities to expand the practice nurse role and further utilise nursing skills. Contracts such as Care Plus, Services to Improve Access, and funded programmes specifically to address inequalities, have all opened up new ways of working for many practice nurses (Sheridan, Finlayson & Jones, 2009). However, some insecurity exists about the financial sustainability of some of these initiatives. To counter this there is a call for more control over and access to nurse specific funding streams within general practice, essential if health gains are to be made (MOH, 2009).

CarePlus, a general practice based programme offering free care and treatment for patients' with long-term conditions, is one initiative which has expanded the role of practice nurses (Finlayson et al, 2009). With an ageing population, longer life expectancy, and an estimate that sixty per cent of all deaths worldwide result from long-term conditions (Hudson, 2005) funding to address this is being devolved into primary care. Practice nurses are playing an ever expanding and important role in the care of patients with chronic conditions.

Cultural 'fit' and competency is a key aspect of workforce capability. Of the 2511 practice nurses in New Zealand only 5.8% identify as Māori (NCNZ, 2010b) making it all the more important that all who work in general practice have a high level of cultural safety and awareness (ICN, 2006; ICN, 2011). Legislation underpins this in the form of the Health and Disability Commissioner Act (1995), the Health and Disability Code of Rights (1996), the Mental Health Compulsory Assessment and Treatment Act (1992), and the Health Professional Competence Assurance Act (2003). These Acts of parliament ensure service providers and health practitioners provide services to consumers that are culturally responsive, culturally appropriate, and meet the needs of the culturally diverse communities that make up New Zealand society (Skegg & Paterson, 2006).

Ensuring cultural competency and capability within the general practice environment is an essential component necessary to meet the burgeoning health demands of the ageing, increasingly unwell population. The poor health status of Māori is attributed largely to a health system which reflects its origins in a dominant European culture that provides care that emphasises and values individualism and self-advocacy, over and above, the more 'holistic' contemporary Māori view of health (Jansen & Smith, 2006).

In primary care the traditional approach to Māori health has been a personal health one whereby 'individualistic' treatment is delivered *to* the patient by the GP and/or practice nurse. The model has focused on disease processes with the health practitioner being the 'expert' with limited regard for the patient being a partner in his/her health or part of a bigger family (Jansen, 2008). The Māori way of viewing the world recognises that health care is not concerned solely with physiological interventions; the physical, mental and the spiritual are all part of the whole, viewed within the context of the extended family /

whānau (Campbell et al, 2005; Jansen, 2008). Whānau ora, an empowerment model whereby people are encouraged to develop their own health plans and trust their own solutions, is a relatively new concept in general practice (Doherty, 2011).

Recent international research confirms people want more than diagnosis and treatment from their health provider (Browne, Roseman, Shaller & Edgman-Levitan, 2010). They also need to have an effective personal relationship with their health providers, one where they feel there is a personal interest in them, their family and their health and wellbeing. Table 7 identifies five attributes patients believe as being important in their relationship with their doctor:

Table 7: Components of patient care which enhance the patient / doctor relationship.

Communication and partnership
Personal relationship (described as knowing their patient & their emotional needs)
Health promotion
A positive approach (including being definite about the problem and when it will settle)
Interest in the effect on the life of the patient

Browne et al (2010); Little et al (2001)

Browne et al (2010) assert there are clear benefits to patient-centered care where there is high cultural awareness and mutually respectful relationship between the health professional and the patient. This results in improved health outcomes including patients' engagement with and adherence to providers' instructions and adherence to medication and other care regimes. It has been suggested that high quality health professional and patient relationships have a correlation to lower medical malpractice risk (Browne et al, 2010).

Increasing the capability of primary health care nurses is essential to ensure health improvements. Improved skills, further education and increasing cultural competency for the predominantly non-Māori workforce are key areas for further development. Attracting Māori to pursue careers in general practice as GPs and practice nurses, and supporting them once they are there, are key challenges that require a collaborative team effort by both the education and health sectors.

Capacity

Increasing capacity of the primary health care workforce by improving size and demographic spread of the workforce is essential. However, workforce capacity issues are not solely about the number of people working in health. Equity, cultural appropriateness, skill mix and empowerment are other important considerations (Health Workforce Advisory Committee, 2005). Inequitable pay rates, variable employment conditions and culturally unsafe work environments influence nurses' views of their roles and their choice of work environments (MOH, 2009) and affect their feelings of empowerment (Fulton, 1997).

The Chief Executive of the Nursing Council of New Zealand stated, "The main concern of the Council is to ensure New Zealand has a nursing workforce that is sufficiently well prepared and flexible to manage professionally and compassionately in the ever-changing environment" (NCNZ, 2010b, p.9). Change is rapid and inevitable and is evident in the realm of expanding nursing practice. Registered nurses are being required to change their way of working, at times undertaking activities that were previously the domain of other health professionals. For some nurses working in general practice the opportunity for expanding nursing practice causes challenges and discomfort as they take on roles previously the domain of general practitioners (Table 8). For others it is the opportunity many have long awaited.

Table 8: Issues affecting the capacity of practice nurses to work in an expanded role.

Ineffective recruitment and retention strategies for practice nurses
Poor pay equity with their DHB peers
Perceived lack of status and role confusion
Lack of nursing leadership and governance
Employer / employee relationship between GPs and practice nurses
Predominantly part-time workforce
Inappropriate and unreasonable workloads
Lack of an attractive career pathway
Lack of opportunity for release time for post-graduate study
Professional and geographical isolation for rural practice nurses
Generalist versus specialist focus for rural nurses

Clendon (2010); Finlayson et al (2009); Hefford et al (2010)

Evidence shows that increasing the representation of ethnic groups in the workforce, to provide care for their own people, has potential to improve and increase positive health outcomes for people living in marginalized communities (Cooper & Powe, 2004). Māori and Pacific nurses make up less than nine per cent of the practice nurse workforce and yet both ethnic groups are high users of primary health care (HWIP, 2010; NCNZ, 2010b).

Table 9: Profile of the practice nurse workforce, 2010

Total number of nurses identified as practice nurses: 2511
Total number who identify as Māori practice nurses: 146 (5.8%)
Total number who identify as Pasifika practice nurses: 74 (2.9%)

Nursing Council of New Zealand (2010)

There is a well recognized need to develop the Māori and Pacific health and disability support workforce if the principles of equity and appropriateness are to be addressed (HWAC, 2005). This is particularly relevant in New Zealand as the population continues to change with growth, diversity and redistribution of populations creating different pressures across the country. Ethnic diversity is increasing with Māori, Asian and Pacific populations increasing. Due to their higher birth rates the forecast for an increase in the non-European population for the twenty years between 2006 and 2026 is a rise from 23 percent to 31 percent. The Māori population is projected to be 16.6 percent of the total New Zealand population in 2026 compared with the current 14.9 percent. Population distribution is also changing with concentrated growth in urban centers and much less growth in rural and smaller centres (HWAC, 2005).

Along with redistribution of populations is the changing family structure and age distribution that will have a profound effect by increasing demands on the health workforce. The over 65 age group is forecast to grow over twenty years from 13 percent to 19 percent of the total population. The growing proportion of people living with chronic health conditions (diabetes, chronic respiratory disease and heart disease) is forecast to double over the next twenty years due to changes in people's lifestyle behaviour within an increasingly urbanised society (MOH, 2010).

In 2010 the total number of nurses with annual practicing certificates in New Zealand was 51,762, with 4.8% identifying as practice nurses. The majority of practice nurses work as employees of self-employed GPs (64.2%) within a private business model (NZNC, 2010b). A small number are employed directly by PHOs, or community trusts such as the Newtown Union Health service in Wellington and Te Puawaitanga o Otangarei Health Care centre in Whangarei (Gray, 2005; Manaia Health, 2009; Mel Pande et al, 2006). All are working at the ‘coal face’ managing people with an increasingly complex array of health conditions in a diverse and challenging world.

Feeling valued increases capacity and nurses’ ability to practice effectively. Feeling discouraged and disempowered due to inequitable pay rates has been a feature of recent industrial and political developments in New Zealand (Clendon, 2010; Finlayson et al, 2009). Reports sourced within the literature review have identified pay inequity between practice nurses and their District Health Board (DHB) counterparts. In 2004 a national MECA (multi-employer collective agreement) between DHBs and the New Zealand Nurses Organisation (NZNO) set a new benchmark for primary health care nurses working in DHBs. This agreement signaled the beginning of significant pay differentials in the primary sector, leaving practice nurses with significantly lower pay rates than their DHB colleagues resulting in a migration of nurses from primary to secondary care (MOH, 2009).

Table 10: Comparison of hourly pay rates for practice nurse & DHB employed registered nurse, 2011.

Step	Practice nurse hourly rate(as of 1/9/11)	Step	DHB employed RN rate (as of 1/1/11)
Merit 2	\$30.64 (top step)	Merit 2	\$31.94 (with 22 more steps ↑)
Merit 1	\$29.54	Merit 1	\$31.31
5	\$28.54	5	\$29.50
4	\$25.93	4	\$26.55
3	\$24.36	3	\$25.13
2	\$22.50	2	\$23.65
1	\$21.36	1	\$ 21.85

Source: Primary Health Care Multi-Employer Collective Agreement: NZNO / NZMA (1 September – 31 August 2012) & District Health Boards / NZNO Nursing & Midwifery Multi-Employer Collective Agreement (1 April 2010 – 30 September 2011).

Currently there is a union led campaign to address this but to date pay parity for primary health care has yet to be realized (Clendon, 2010) affecting the ability to recruit highly qualified, experienced nurses into primary care.

Critical social theory

Themes of nurse disempowerment have emerged throughout the literature review. Barriers to the development of the practice nurse role have been identified that include power differential and disconnection between the practice nurse, their employers, their professional colleagues, patients and government policies. To increase understanding of this phenomenon an examination of the issues using the theoretical framework of critical social theory is used.

Theoretical under-pinning

Contemporary critical social theory emanates from the Marxist-orientated school of German scholars in response to the catastrophic ideology that resulted in the two world wars of the 20th century (Fulton, 1997; Grant & Giddings, 2002). Its evolution is influenced by the great humanitarian Paulo Freire's work to improve literacy in marginalised and under-privileged communities (Freire, 1972). Critical social theorists seek to recognise and understand the underpinning power-bases of society. Through 'bringing to light' the root causes of injustice and by gaining understanding of the effects of power in society people can strive for freedom and liberation (Manias & Street, 2000).

In difference to its name, critical social theory is a 'school of interdisciplinary thought' rather than a theory. It explores the phenomena of values, knowledge and power often asking the questions, "Whose interests are being served in this relationship?" or, "What is the aim of someone who possesses power?" (Foucault, 1980, cited in Manias & Street, 2000, p.53).

Power in the context of people working in organisations is defined by Kanter (1993) as, the ability to mobilize resources, give support and supply information in order to get things done, to create conditions that empower employees to achieve their work goals in a meaningful way.

Nurses and empowerment

Empowerment is an important concept of nursing requiring both the provider, (the nurse), and the recipient of the health service, (the patient / client), to be empowered in order for them to each achieve their goals. It is contended that nurses need to firstly feel empowered themselves to enable empowerment of their patients / clients (Spence-Laschinger, Gilbert, Smith & Leslie, 2010), that in turn has a positive effect on patients / clients seeking self-determination to improve their health.

The notion of nurses being a disempowered group has been explored in several studies (Lovell, 1982; Street, 1992; Ford & Walsh, 1994 cited in Fulton, 1997). Nurses participating in a 1996 British study on empowerment, albeit a small-scale study with 16 participants, manifested signs of oppression with four major themes emerging from the study (Fulton, 1997).

The participant's in Fulton's study did not feel they were empowered but did not actually articulate this as such, describing rather their lack of power through negative examples of decision making, choice and authority (Fulton,1997). Kanter (1993) asserts when employees have access to the opportunity and power structures within an organisation they feel empowered and are more likely to motivate and empower others to work autonomously. Conversely, if they feel they have no control over their work situation nurses are more likely to feel frustrated and disengaged, conditions that are linked to negative health and well-being (Thomas & Ganster, 1995 cited in Spence Laschinger et al, 2010).

Table 11: Four major themes of nurses' views on empowerment

Empowerment
Having personal power
Relationships within the multi-disciplinary team
Feeling right about oneself

Fulton (1997, p.531)

Empowerment

The review of literature in this study has identified practice nurses, over the years, experiencing an imbalance of power and lack of opportunity to expand their roles in a

number of ways. The Practice Nurse Subsidy Scheme (PNSS) introduced in 1970 was intended to liberate practice nurses to take up a more patient focused role. However, as it was paid directly to the general practice business owners the development of the practice nurse role remained at the discretion of another professional group, the medical practitioners who owned the businesses.

Employer influence

Despite the intent of the PNSS to expand the practice nurse role, by enabling autonomous practice, many GPs utilised the role at their whim that was largely dependent on what their own workload was (Kent et al, 2005; Docherty, 1996), rather than supporting the expansion of an autonomous nursing role.

The disempowerment of practice nurses continued into the 1990's when the guidelines for the PNSS continued to support role confusion and power / authority differentials between general practitioners and practice nurses, resulting in lack of nurse autonomy (Carryer et al, 1999).

Political & policy influence

The implementation of the Primary Health Care Strategy (2001) heralded the beginning of a seismic shift of power within primary care service delivery. Nurses were to play a crucial part in enabling improved access to health care historically dominated by general practitioners (Cuming et al, 2005; Finlayson et al, 2009; MOH, 2001). Nurses and political analysts were now asking the critical social question; "Are the interests of patients being best served in this medically dominant relationship?"

Attitudes

GP attitudes, and a propensity for patients to feel better served by a doctor rather than a nurse, have limited, and in some places prevented the development of the practice nurse role. Finlayson et al (2009) reported less than 30 per cent of practice nurses were satisfied with their careers and unable to see opportunities available for them in their current role. Acknowledging new opportunities are available for further education, some nurses lack

confidence and personal power to be proactive about increasing their level of autonomy (MOH, 2009).

Having personal power

As did the participants in the research ‘Nursing developments in primary health care 2001-2007’ (Finlayson et al, 2009), the nurses in Fulton’s study linked empirical knowledge with assertiveness and power. The nurses recognised the importance of having rational knowledge to enhance their ability to challenge, disagree, act and empower others (Fulton, 1997).

In New Zealand two national surveys of practice nurses, in 2001/2002 and 2003, confirmed that practice nurses lacked power due in part to limited possibilities for post-graduate education, exacerbated by lack of relief staff to allow release time for study. Another factor disempowering practice nurses at the time was the under-utilisation of their range of skills, due to limited funding to enable the introduction of new nurse-led programmes (Kent et al, 2005; MOH, 2003). Expanded nursing practice was largely dependent on the personal and dominant view of GPs as employers causing under-development of the wider primary health care team and limiting service provision (Cuming et al, 2005; Davis, 2005; Finlayson et al, 2009)

Relationships within the multi-disciplinary team

The participants in Fulton’s study articulated the direct power of doctors being a problem by limiting the nurses’ autonomy within the multidisciplinary team. The exercise of authority by doctors over nurses caused doubts in the nurses’ knowledge and ability (Fulton, 1997). In New Zealand the funding formula in general practice also limits nurses’ autonomy, with many GPs still working in the old ‘fee-for-service’ model despite the capitation model introduced with PHOs. GPs dealing with patients directly, instead of referring them to the practice nurse, is sometimes related to accessing the higher amount paid to see a doctor compared to a nurse (MOH, 2009).

Similarly, the literature review for this dissertation identified the imbalance of power between GPs and practice nurses as being a factor inhibiting practice nurse autonomy.

Underpinning the issues is a common thread of power differential. This manifests in several ways including; unclear role definitions; limited access to further education by nurses; GPs feeling threatened by nurses taking on more expanded roles; nurses not willing to ‘step up’ to new challenges; lack of visionary leadership by GPs and their professional groups; nurses doing disproportionate ‘non-nursing’ work; narrow and ill-defined parameters of care within the general practice team; and a paucity of Māori and Pacific nurses working in primary care despite Māori / Pacific people being the highest service users (Clendon, 2010; Finlayson et al, 2009; Halcomb et al, 2005; HWAC, 2005; Woodward, 2006).

Feeling right about oneself

In the study by Fulton (1997), when asked about their views of empowerment, the participants identified themes of lacking confidence, low self esteem and being manipulated. “The nurses felt they could not advise, challenge or empower others until they were comfortable with themselves...to say how they felt and trust in their own thinking” (p. 533).

The literature review identified the importance of nurses’ under-taking post-graduate education to enhance their feelings of professional self-worth. This has long been recognized as an essential component needed to develop and expand the role of nurses to achieve what Carryer describes as, ‘transformational’ change. Advanced education gives nurses the opportunity to develop clinical competence, enhance a sense of professional confidence and identity and, importantly, to gain and grow the trust and professional respect of their medical colleagues (Carryer, 2011). However, access to education and training, particularly in rural areas, is restricted for many nurses with significant physical and geographical barriers (Finlayson et al, 2009). Lack of a coherent national framework for primary health care nursing education is identified as a significant barrier (MOH, 2009).

Conclusion

For this dissertation the literature reviewed both historical and contemporary reports on the role of nurses working in New Zealand. Both barriers and opportunities for practice nurses expanding their roles have been identified within the context of historical and current models of primary care service delivery.

The practice nurse subsidy, introduced in 1970, was the first step towards enabling practice nurses to expand their role through government funding. Forty years later many practice nurses remain in the private business model as employees of the general practice owner. Some changes to their role have been possible with the introduction of publically funded health programmes. This targeted funding has gone some way to enabling and empowering practice nurses to expand their role, to meet the diverse needs of their enrolled populations, but uncertainty remains about funding sustainability.

Within the ‘better, sooner, more convenient’ drive of the current government, challenges are being made to the dominant medical model of primary health care. With this shift of power and dominance by one professional group the role of the practice nurse is slowly changing but the current GP dominated funding model is still a significant barrier to making systematic and sustainable change.

It is yet to be proven that Integrated Family Health Centres are the solution to ensure primary health care outcomes improve. What is known from the evidence is that health care services delivered by teams of people working together with a common cause, with a sense of shared responsibility and a collaborative approach will improve health for all New Zealanders.

CHAPTER 3: METHODS & METHODOLOGY

Introduction

Methodology is the theory and analysis of how research does or should proceed. Within the methodology the outcome of the research study will reflect the researcher's position or theoretical stance (Grant & Giddings, 2002). Using a qualitative descriptive exploratory methodology this dissertation has explored practice nurses perception of opportunities and barriers to the expansion of nursing roles within contemporary general practice.

Qualitative research deals with the issue of human complexity, assuming that people have an ability to influence their life experiences, and that truth is found amongst people's day to day realities (Polit, Beck & Hungler, 2001). For the four practice nurses interviewed for this research, their day-to-day realities are similar in that they all work in practice nurse roles with many of the same day-to-day tasks, interventions and treatments. They all work within the registered nurse scope of practice as set down by the Nursing Council of NZ. There are differences in the configuration of the four practices; one is a single GP practice; one is a rural group practice; two are urban group practices. Two general practices are located in quintile 5, high deprivation areas (NZDep2006) and two practices are located in quintile 1- 4 (NZDep2006) (White, Gunston, Salmond, Atkinson & Crampton, 2008).

The aim of this research is to explore practice nurses' perception of factors which shape the development and expansion of nurses' roles. The information gained will be used to inform the change required to deliver 'better, sooner, more convenient' primary health care (Ryall, 2007). This will assist the development of nursing roles within future integrated family health centres in the area where I work as a primary health care nurse leader.

A qualitative descriptive methodology was used for the dissertation. This methodology is used when a straight description of a situation is required. The researcher asked open ended questions by interview, the interviews were taped and data was collected. Following the interviews the tape recordings were transcribed and an analysis of the data was undertaken

using thematic analysis. This involved both the creation and application of codes to the data obtained through the interview transcripts. Using a six phase process an analysis of the codes and themes established meaning and intent of the data and, through this process, key themes emerged (Braun & Clarke, 2006; Neuman, 2003; Seaman, 1987).

Descriptive qualitative research

A descriptive qualitative research design enables the researcher to describe the participant's experiences and situations. The study design is useful when the researcher wants to focus on open ended questions such as 'how', 'what', 'who' and 'where', to gain insight into situations, social settings and relationships (Burns & Grove, 2001; Gribich, 1999; Neuman, 2003).

To allow time for the nurses to reflect on their experience the five open ended questions were sent to the participants prior to the interview. Using the open ended questions in the interviews allowed the participant's to express and describe their view on the topic being explored. The questions asked were;

1. What is your understanding of expanded nursing practice?
2. What are the opportunities to make this happen?
3. What are the barriers to implementing expanded nursing practice?
4. How can some of the identified barriers be overcome?
5. What professional development is required to support the development of expanded practice for practice nurses?

As in all qualitative research the purpose of the dissertation was to 'give a voice' to the practice nurses. The methodology and analysis of the data using thematic analysis also gave the possibility of discovering new perspectives (Kearney, 2001). This was to gain further understanding of the barriers and opportunities facing practice nurses in their quest for expanding and enhancing their roles.

Ethical considerations

Legislation in New Zealand clearly defines the legal responsibilities of health professionals with regard to ethical practice prior to undertaking research (New Zealand Government,

1994). These guidelines are based on a set of five principles whereby no harm is done to the participants, participation is voluntary, informed consent is given by the participants, there is no deceitful practice and confidentiality is maintained (Tolich & Davidson, 1999).

The five principles are described in relation to ethical considerations in all research.

Do no harm: All research has the potential to do harm. This principle clearly states that researchers should never harm the people involved in research. Treating the participants with respect, keeping them fully informed with written and verbal information, and giving them assurance that their information is kept confidential, and their identity safe-guarded, is part of ensuring no harm is done (Tolich & Davidson, 1999). To minimise harm in the event of emotional issues arising for the participants during research the availability of support and counseling is offered prior to commencement.

Participation is voluntary: A major principle in contemporary research is participation must be voluntary and participants need to be informed about what is involved before the research commences. Consent is sought on the basis that participants are fully aware and informed about what they are taking part in, and that no coercion is used to involve people in the research (Tolich & Davidson, 1999).

Informed consent: The Code of Health and Disability Services Consumer Rights (The Code), states that all participants in health research must be given full explanations of the processes and procedures about the research, and they must give written consent. This is explicit within right 7(6) of The Code that states written consent is required for participation in research; experimental procedures; and when there is significant risk of adverse effects on the consumer. Information sheets given prior to the research commencing need to be clear and written in understandable language outlining the aim and objectives of the research. (Health and Disability Commissioner, 1996; Skegg & Paterson, 2006; Tolich & Davidson, 1999).

No deceitful practice: Participants must be fully informed and conversant with the nature of the research before commencement; deliberately deceiving them is unethical. Any risks

must be outlined prior to the research commencing, with the option to withdraw from the research clearly explained. Integrity of the research process is maintained by open, clear communication between the researcher and the participants (Tolich & Davidson, 1999).

Confidentiality and anonymity is maintained: As part of the informed consent process an agreement is entered into between the researcher and the participant that the data gathered in the research is kept in the strictest confidence. Names, places and references which can identify people involved in the research are kept confidential in the text using pseudonyms and generic references (Tolich & Davidson, 1999).

Participant selection

The decision about who is involved in the research greatly determines the reliability of the outcome (Boyatzis, 1998). Thematic analysis is particularly sensitive to the type and quality of the raw data and information gained. For this research a purposive sampling method was used whereby participants were chosen for their particular knowledge and experience of the phenomenon in question (LoBiondo-Wood & Haber, 1994). All were practice nurses who had a minimum of two years working as a registered nurse in a practice nursing role within general practice. The nurses worked in four types of general practice: urban, rural, single and group practices. All the general practices are part of the same rural primary health organisation (PHO).

Rather than approaching the nurses directly I sent an information flyer to the practice managers of each of the four general practices seeking one registered nurse participant from each practice (Appendix 1). Requesting an intermediary person, the practice manager, to display the flyer on the general practice staff notice board meant I was not involved in the selection process, eliminating the potential for coercion and bias. Initially there was no response to the flyer. Once the date for expressing interest in participating in the research had passed a nurse leader working within the geographical area was asked to make contact with each of the four practices to alert the practice nurses to the flyer on the staff notice board. Over a period of two months four nurses contacted me indicating they would like to find out more about the research.

My first connection with the nurses was by telephone. It was made clear that participation was voluntary, and they were free to withdraw from the research at any time during the interview up until the time the data collection was completed. Following my telephone conversation, and once their interest was ascertained, a participant information sheet was sent to each nurse (Appendix 2). Following receipt of the information sheet the four practice nurses indicated they wished to participate in the research and a date, time and venue for the interview was agreed on.

Informed consent

The participant information sheet sent to each nurse prior to the interview outlined the purpose and process of the research, possible discomforts and risks, benefits, privacy protection, how to join the study, and gave the opportunity for the participants to receive feedback in the form of a written report. Prior to each interview the participant was given further opportunity to discuss the details of the research and the process for maintaining confidentiality and privacy.

Each participant was given a consent form to read and sign (Appendix 3) that was retained by the researcher until the final report was finished. Following completion of the research the consent forms will be retained by the research supervisor for a period of six years stored in a locked cabinet, separate from the data transcripts.

Anonymity and confidentiality

Tolich & Davidson (1999) identify possible confusion about what is the difference with anonymity and confidentiality. The nurses are known to me. They are therefore not anonymous participants in the research but it was important to ensure anonymity for them to protect their identity to others reading the research findings. New Zealand's small size makes it relatively easy to identify places, people and institutions, therefore any references to these in the dissertation are made in a generic way. Likewise, the practice nurse population is a relatively small cohort of people so therefore complete anonymity cannot be totally assured. However, in contrast, total confidentiality of the participants was assured.

The nurse's identity was kept confidential by me at all times. The only other people who had an awareness of individual participation would be the intermediary people who assisted to seek the participants. No real names were used in any reports of the study with the participants choosing a pseudonym (false name) prior to the interview. The pseudonym was used in the recorded interviews and in all the typed transcripts. The person who typed the transcripts signed a confidentiality agreement prior to undertaking the transcribing.

To further ensure confidentiality the tapes and the transcripts were stored in a locked filing cabinet, the computer used for the writing of the study was password protected, and the signed consent forms were stored separately from the data. After completion of the study the research supervisor will maintain all information from the study in a secure place for six years after which it will be destroyed.

Data collection

The data for the research was obtained through face-to-face interviews with the four participants. Each interview was recorded using an audio-tape. The taped interviews were then transcribed and the data was analysed using thematic analysis. Boyatzis (1998) states thematic analysis can be used in a number of ways, as a way of; seeing; making sense; analyzing; systematically observing (people, interactions, groups, cultures) and converting qualitative data into quantitative data. Braun & Clarke (2006) recognise one of the benefits of thematic analysis is its flexibility as it is "not wedded to any pre-existing theoretical framework, and therefore it can be used within different theoretical frameworks" (p.81).

The interview process

After reading and signing the research consent form the four practice nurses each participated in a face-to-face interview. Each interview varied in time from thirty minutes to one hour and ten minutes. The interviews took place at a venue chosen by each of the nurses. One interview was in a workplace after hours, and three took place at an independent health organisation that was located near the nurse's place of work. The interviews were structured using the same five open-ended questions (Appendix 4).

When arranging the interviews two nurses requested the questions be sent to them prior to meeting so they could be 'more prepared'. After consulting my supervisor it was agreed the questions would be sent to all four participants prior to the interview to ensure consistency with the research process.

The interviews were audio-taped. Following the interview the tape was checked to ensure the recording was clear. One interview had to be repeated because the audio-recorder had not worked properly. The interview was repeated immediately so that the original data could be captured. However, the resulting transcript showed that the repeat interview for this participant was much shorter than the other three interviews, indicating it was less detailed. Following the interviews the audio tapes were given to an independent typist to transcribe.

Honesty about the research process was maintained by giving clear and easily understood information, both in written and verbal form, prior to the interviews. Preservation of the integrity of the raw data was ensured by providing the participants with the typed transcripts following the interview. A stamped addressed envelope was included with the transcript, and a request was made to return the data to the researcher within four weeks. Three out of four of the participants returned the transcript with some minor alterations. It was made clear to the participants throughout this process that if they chose to withdraw from the study their data would be destroyed immediately.

Data analysis

Transforming the data into findings entails reading and rereading the data to enable common themes to emerge, at the same time reducing the large amount of raw data into manageable 'piles' (Neuman, 2003; Patton, 2002). This is a 'step-by-step' process used to transform raw text from transcripts into a narrative. To guide the thematic analysis a six phase framework was used (Braun & Clarke, 2006). This process enables participant's experiences of a situation to emerge and become 'uncovered' (Seaman, 1987), enabling a framework to emerge for further discussion and potential research.

Phases of thematic analysis

A six phase guide to performing thematic analysis was used: Becoming familiar with the data; generating initial codes; searching the themes; reviewing the themes; defining and naming the themes and; producing the report (Braun & Clarke, 2006).

Table 12: Phases of thematic analysis

1. Familiarizing yourself with the data
2. Generating initial codes
3. Searching the themes
4. Reviewing the themes
5. Defining and naming the themes
6. Producing the report

Braun & Clarke (2006, p. 87)

Familiarising myself with the data: Finding the ‘codable moment’ entailed reading and re-reading the data as well as listening to the audio tapes following the interviews. The first reading of the transcripts gave an early sense of the data and an appreciation of what Boyatzis describes as, its ‘richness’ (Boyatzis, 1998, p.11). The research question was kept in focus as I read the transcripts and searched for codes and themes, at all times asking, “What are the opportunities and barriers to expanding practice nurse’s roles? ” and, “What is happening here?”

Generating initial codes: Finding the initial codes entailed firstly, listening to the tapes following each interview, then reading and re-reading the data once the transcripts had been typed. Making notes, highlighting key words and phrases, and systematically coding what Braun & Clarke (2006) describe as “interesting features of the data” (p.87) was part of initial identification of codes. As part of this stage the transcripts were read with my supervisor, and further data relevant to each initial code was collated. Together we compared key words and phrases which had emerged for each of us. Eight codes emerged; leadership, education, remuneration, university barriers, feeling valued, applying theory, family stress, and isolation.

Searching the themes: The third phase of data analysis was searching the codes for themes, the phase which follows when all data has been coded and collated, the phase when

codes become themes. Braun & Clarke (2006) describe this phase as the beginning of analysis, when codes start to combine to form “overarching theme” (p. 89), when the researcher begins to think about the inter-relationships between codes, themes and the different levels of the themes. By the end of this phase themes and sub-themes are identified and all codes are now part of a theme or themes.

In this ‘searching’ phase each interview transcript was further read at the same time as listening to the audio-tape. Further words and phrases were marked using coloured pens to highlight key codes. Comments were noted in the margin on the transcripts. The challenge to establish the meaning and intent of the data was assisted by constantly referring to the research question and asking ‘What is this about?’ and “Where does this fit?” During this process the data was further colour coded using the cut and paste and highlighter function on the computer that enabled the codes to be merged into potential themes (Braun & Clarke, 2006). Reducing the data into manageable piles, by cutting the typed transcripts and placing them on a table in their colour coded categories, assisted to literally ‘see, feel and code’ the data and enabled a sense of being fully immersed in it. This visual exercise assisted themes to emerge.

Assistance was sought from my supervisor following the point of categorising and identifying the key themes. Further searching, refinement and analysis of the themes were required with the research question being mirrored in all aspects of the process. I constantly asked the question, ‘What are the opportunities and barriers to the expansion of practice nursing roles?’ This resulted in the emergence of three overarching themes:

- 1. Practice nurses have opportunities, but face barriers when accessing post-graduate education to enable expanded nursing practice.*
- 2. There are links between expanded practice, remuneration and nurses feeling valued.*
- 3. Nurses who undertake post graduate study experience enhanced professional self-esteem.*

These themes became more refined as the data was further reviewed and analysed.

Reviewing the themes: The fourth phase of data analysis is reviewing the themes and refining the data, a phase described by Braun & Clarke (2006) as, ensuring data comes together “meaningfully” (p.91). This stage involves re-visiting the codes used in the initial data analysis prior to the formation of themes. As a result of this phase the codes within the three identified themes were reviewed, refined, broken down and analysed with some codes seeming not to fit. These were moved.

An example of ‘reviewing and refining’ during the data analysis was the process of refining the initial code about the value of nurses. Initially three separate codes were used to code ‘value’; the view of practice nurses as ‘hand maidens’ (*code: negative value of nurses*); the ‘added value’ practice nurses make to contemporary practice (*code: positive value of nurses’ work*) and; the issue of low remuneration for practice nurses compared to other primary health care nurses (*code: being undervalued demonstrated by poor pay*). During the review phase these three codes were refined into one code ‘*being valued*’ that emerged in the final analysis as a sub-theme of the overarching theme *professional self-esteem*.

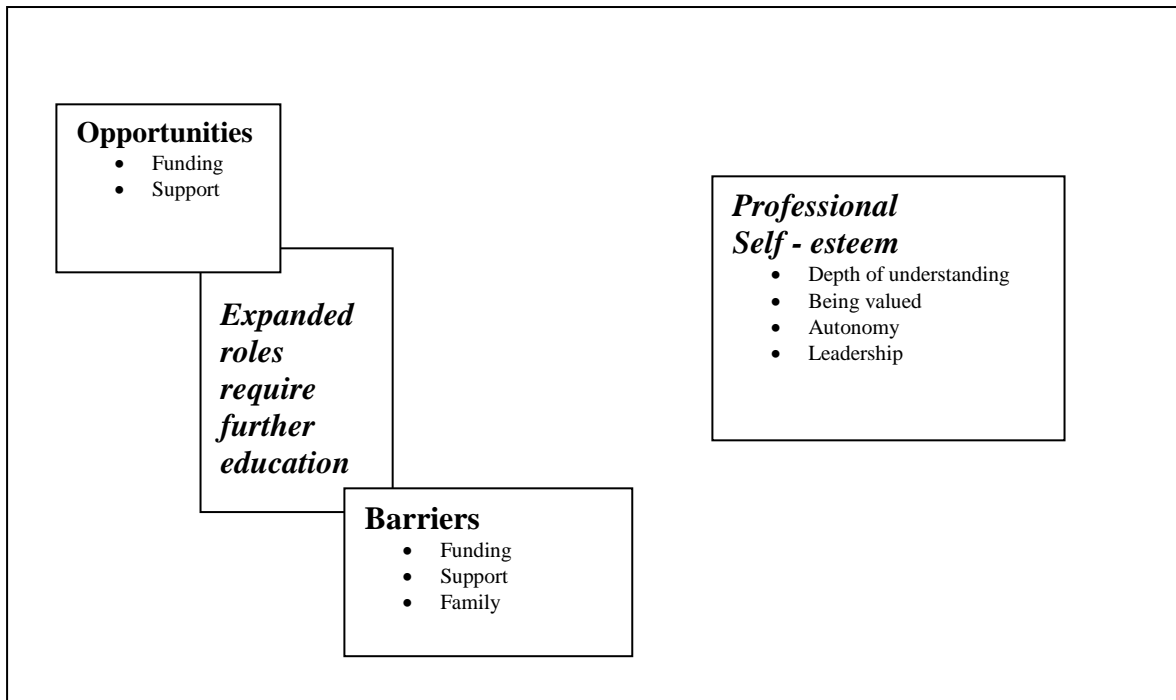
Defining and naming the themes: The fifth phase of thematic analysis defined by Braun & Clarke (2006) is the ‘defining and naming themes’ phase that entails identifying the “essence of what each theme is about” (p.92), and what they are not. This is the time to go back to the collated data and select narrative which supports the analysis and emergent themes. When refining the themes, sub-themes may emerge. These sub-themes can be helpful if a theme is complex or large. It is the time when the themes are named reflecting the refining process. “. . .names need to be concise, punchy, and immediately give the reader a sense of what the theme is about” (p.93). Two overarching themes and two sub-themes emerged from the data during the refining phase:

1. ***Expanded roles require further education:*** (two sub-themes; *opportunities and barriers*)
2. ***Professional self-esteem:***

Through this process, meaning or intent of the data was established and analysed (Seaman, 1987). This required a process of becoming fully immersed in the data by reading and re-

reading the transcripts, listening and then re-listening to the audio tapes, and discussing the data with my supervisor, all the time attempting to identify emerging themes by asking; “What is happening here?” (Gribich, 1999). Through interpretation of the information, the development of codes emerged into key themes.

Diagram 1: Themes, sub-themes and codes.



Producing the report: Phase six is the final analysis stage when the writing of the report is completed. This is when the large amount of data, and what is often a complex and complicated story, is made into a readable narrative using the evidence of the themes within the data. It is not only a descriptor of what was said by the research participants, it is also an “analytic narrative that compellingly illustrates the story you are telling about your data...beyond description of the data ...an argument in relation to your research question” (Braun & Clarke, 2006, p. 93).

Conclusion

The research method and methodology is appropriate for this research. Qualitative descriptive research explores human complexity, acknowledging people have an ability to

influence their life experiences and that truth is found amongst their daily realities (Polit, Beck & Hungler, 2001). The interviews of the four practice nurses resulted in rich narrative data about their 'day-to-day' experiences working in general practice in 2011. Through thematic analysis the nurses' experiences merged into key themes:

1) That further education is required before nursing roles can be expanded, and 2) Nurses who take up the opportunity for post-graduate education experience enhanced professional self esteem.

The themes in this dissertation will help guide future developments of the practice nurse team in the area where I work. Together we will work towards nurses expanding their roles to become an integral member of the team that will improve the health of the population served.

CHAPTER 4: RESEARCH FINDINGS

Introduction

This chapter presents a thematic analysis of the experiences of four registered nurses working in general practice in relation to the research question: *What are practice nurses' perceptions of opportunities and barriers to the expansion of nursing roles within contemporary general practice?*

Pseudonyms were used to protect the identity of the nurses. All references and details within the audio-taped interviews that could identify the nurses have been removed. Where narrative quotes by the participants are used, they are italicised (*italicised*), and reference is made to the nurse's pseudonym. When the text has been edited to remove words, (without changing meaning), a series of three full-stops (...) are used.

The four participants interviewed are registered nurses currently working in general practice. Their length of time employed as a practice nurse is between nine and twenty years. Three of the participants have undertaken post-graduate education, two to the level of post-graduate certificate, and one to the level of post-graduate diploma. All four nurses are women, all identify as New Zealand European, with two nurses born in countries outside of New Zealand. All four nurses live and work in an area that does not have a university offering post-graduate education.

The nurses, and the population they serve, live in one of the most deprived districts in New Zealand with 30% of the total population identifying as Māori. The area is predominantly rural with medium to small towns, long distances to travel to main service areas and a scarcity of public transport. 35% of the population lives in quintile 5 areas, the most deprived areas on the NZDep2006 scale (White et al, 2008).

As outlined in the previous chapter two main themes and two sub-themes were identified. These are:

1. Expanded roles require further education, with the sub-themes being “opportunities” and “barriers”.
2. Professional self-esteem.

Theme 1: Expanded roles require further education

The New Zealand Nursing Council’s definition of expanded nursing practice includes reference to a health care activity or role that is currently outside the nurse’s scope of practice and that may have previously been the responsibility of other health professionals. Competencies developed to describe the skills and knowledge of nurses working in expanded roles includes the requirement for post-graduate education (NCNZ, 2010a).

All four of the participants articulated the need for further education in order for nurses to work in an expanded role, identifying this to be post-graduate education.

Gold star, certainly is post graduate study, even at the lower level, I think that the post graduate cert is minimum and I think it would be good for all practice nurses to aim towards. Helen

there is certainly a need for education to make it happen...particularly being in a rural area where we need more availability to education...post graduate (education) Jill

it’s an expansion of practice nurse roles, but with a deeper understanding through further (post-grad) education to give more holistic care to the patient and their families. It includes self responsibility to do that extra professional development Anne

...learning to be a nurse practitioner and being able to prescribe ...a nurse who does a specialty ...the nurse is going to need some more education...university papers as she would need to go into more depth Claire

As well as post-graduate education Claire recognized expanded practice includes taking on the domain of other health professionals:

...a nurse who might take on a role that previously might have been done by someone different Claire

All the nurses recognised the need to continue to support practice nurses with short courses as part of the 'hands on' practical training of practice nurses:

...post graduate and also just updating of your smear taking, immunization, plastering Jill

...really great to balance clinical and theory within practice... it's not just all about theory and study it's about having that clinical hands on because that's the most important part for me as a practice nurse. Anne

Small courses can be beneficial...you can still up-skill and be good at those things without...doing the depth of the post-grad cert... Helen

Claire described gaining depth of understanding from attending post-graduate level study:

...because you attend it and then you go home...you actually have to write something or go to the books and pull up references, actually study it that way you learn and you then apply that learning in your practice Claire

Helen identified becoming more politically aware when doing post-graduate study:

I think in broadening horizons...when we first started (doing study)...looking at the political side...you do need to know it and I became really interested in it... Helen

Anne talked about expanded practice as being part of a practice nurse job description and integrating theory into everyday practice:

... expanded practice or competence levels...could be built into your job description as part of your role and then have time as part of your day to fulfill that Anne

On-line training was seen as a viable option for one nurse:

I like the online courses, now that they have put the immunisation update course (on-line)...for me that's great... it's one of those things that works for me...Helen

A possibility for another:

I think we need the specific training back for practice nurses – it could be online, but I personally believe it's better to go to courses where you can be with other nurses and share experiences...you learn a lot better Jill

On-line training was not an option for another relating this to being professionally isolated:

a lot of people find this on-line learning very difficult...with online learning you're really by yourself Claire

Theme 1: Sub-themes: Opportunities and barriers

During the phase of analysing the data, the defining and naming themes phase (Braun & Clarke, 2006), two sub-themes emerged; opportunities and barriers to further education. Using these two sub-themes I went back to the original transcripts and collated data extracts and selected narrative from the participants to support the emergent themes. Through this process it emerged the two sub-themes supported the main theme and helped to refine the data making it more manageable. They also directly reflected the research question identifying opportunities and barriers to expanding nursing practice.

Braun & Clark (2006) describe the reporting of themes and sub-themes as an “analytic narrative that compellingly illustrates the story you are telling about your data...beyond description of the data ...an argument in relation to your research question” (Braun & Clarke, 2006, p. 93). To reflect this approach I report the two sub-themes as a comparative analysis rather than separating them into two sub-themes. This approach enables a readable narrative which demonstrates the ‘push and pull’ of the identified opportunities and barriers.

Opportunities and barriers include funding, support and family.

Funding: Opportunities & barriers

In 2007 a new post-graduate funding model was introduced by the Clinical Training Agency with 'ring-fenced' funding made available specifically for primary health care nurses. The following year, further 'ring-fenced' funds were made available for rural nurses and for nurses working in long-term condition management (MOH, 2010). The availability of Ministry of Health funding, through Health Workforce NZ, was mentioned as an opportunity to accessing post-graduate education by the three nurses who had utilized this funding:

There are incentives available now to nurses to expand their practice skills and understanding. I used CTA funding which was essential for me to undertake study. Anne

There is more funding (for post-grad study) out there than there ever used to be. Helen

One participant felt that, despite funding availability, there were other costs which were not met when living away from the education provider.

The cost to do a paper, although you can get funding...this doesn't actually cover all the costs to do a paper, it doesn't cover if you have to go away...the accommodation or transport, it only partially covers it. Claire

I am amazed at how much the papers cost these days, even an online paper when you don't even get the tutor there you know it's the same price as a 'face- to- face' tutor. Claire

Support: Opportunities & barriers

Experiencing both positive and negative support was reported by the nurses who had accessed post-graduate education. Two of the participants experienced lack of support by the university they attended.

Claire expressed frustration that there was little guidance and no personal connection with the tutors at the university:

Universities don't give you guidance... its quite difficult to actually get to talk to a person on the telephone...you leave messages all over the place... I just couldn't get anyone to talk to, I couldn't work my way around the website, it was very complicated. When I eventually did get to speak to someone...she was a bit off hand about it all, she wasn't encouraging. Claire

Claire also experienced lack of recognition of her skills and experience by the tutor at the university:

The nursing tutor from the School of Nursing never asked me about who I was, or what my experience was, or where I wanted to go, or where I worked. I felt I didn't get any guidance... if I wanted to go on studying...I felt disheartened by the whole thing...I haven't done anything more on it... it is so difficult to get any information... on what's available for nurses that want to go and do...what pathway they could go down or what roles they could work towards – there is not a lot available if you are a bit undecided. Claire

Similarly, Anne also reported lack of support from her tutor at the university:

... post grad study, it was really, really hard...It was a huge challenge. Huge challenge with IT, distance, didn't feel very supported, would email my tutor and get asked the question that was in front of me. Anne

Anne, Claire and Helen all reported stepping up to advanced study was challenging:

Working and doing that level of study straight away having not done formal study...not referencing, not doing formatting...was a real challenge. The actual content of the paper was fine, but that other stuff put me right off. Anne

Another (barrier) is computer skills and there's not really anywhere that you can go and learn these skills...I think it's an absolute mine field if you are starting out wanting to do a bit of study. Claire

It was hard work...what I went through ...I wouldn't wish on any young nurse.
Helen

Staffing levels and support from within the general practice team influenced access to study and expanding practice.

Jill identified resistance from practice management and lack of relief staff as being barriers:

There can be management resistance within the practice setting, certainly financial in a rural area, there can be a lack of qualified staff. Jill

Helen identified more time for clinical work can be gained by appropriate skill matching:

...we have employed...she is not a nurse...she does all my recalls... she does all the depo recalls, smear recalls, mammogram recalls...that has taken a massive workload off me and freed me up to be able to do more clinical work. Admin support... it doesn't have to be a registered nurse. Helen

Helen questioned how the role of the general practitioner could change to support nurses doing more:

How do you change the employers... to try and get GP's to see how valuable nurses can be and how much they actually can do and take off their workload...ways for them to learn to feel confident with their nurses doing more...? Helen

Claire identified some nurses as not supporting expanded practice:

A few nurses... are quite happy just to do as the doctor directs and they don't want to know anymore than that. Claire

Availability of relief staff and support from the general practice team are important:

...locum nurses certainly help with that, and I think that it's great that the PHO has taken that on board and they are trying to get more relief nurses. Helen

...another barrier with the availability of being able to do extra study, whether it's to do with your staffing levels, being released from work, how important your team

feels for you to be doing that to support you. Support doesn't necessarily just mean financial support. Anne

Availability of work space is a support factor:

If you haven't got your own independent work space, again, you can't go anywhere – the environment certainly plays a factor. Helen

Helen reported a past experience of receiving little support for further education from her employer that differs from her current employer:

Employers... at another practice I have worked at, virtually no support what so ever; no encouragement to do anything...that was one of the reasons why I moved...employers just not interested in me doing anything, I had no job satisfaction... I really felt that I was becoming unemployable... If I didn't get some broader experience within practice nursing I was going to be completely unemployable...that was a really different situation to what I find myself in now... Helen

Anne articulated a model of clinical and academic support she received when working in a general practice in another district in NZ:

...we got incredible support as practice nurses ...we had a practice nurse mentor who was not attached to a practice...she visited us as an independent practice nurse, she would pop in and see if we needed any help... or if we wanted to talk to her about any issues. If we needed an update, she would be that person that you could contact... it was excellent. Anne

Lack of time within the practice environment was another influence:

There are more things that I would like to do and would like to be involved in, but just couldn't physically fit more in to the day as it. Helen

Two nurses spoke about the explicit and implicit pressures to do post-graduate study:

A lot has to do with time, time to actually attend courses...to go to Auckland...time to do assignments.....one of the biggest barriers for me is driving down to Auckland and driving in a big city. Claire

There's a lot of pressure for nurses to do post grad study now...practice nurses in the team that I work in ...they felt pressured to do that study and maybe it was a timing thing, found it really difficult, felt out of their depth, maybe they weren't supported enough in the electronic / IT side of it, they knew the nursing stuff, just needed help with the academic / IT. Anne

Family: Opportunities & barriers

The three nurses who had done post-graduate study spoke about the high level of stress placed on their family whilst under-taking further education:

I worked, I ate, I slept, I studied, and my family felt really, really cheated, so yes, pressure. Anne

...study puts a lot more time pressure on...when you have young children at home and a working husband it does put a lot of stress on...It just about ended in a divorce! I had young children and I was heading back into work and thought I really need to up skill...But it was hard work, a lot of hours down there away from home...young children. Helen

Sacrificing family life and being away from home...not having any area to study...fighting to get onto the computer... solo parents having to look after the family and do studying at the same time is not easy. Claire

... it was not easy but I got through it, but I thought it wasn't fair on my children or my marriage to go any further, not until my kids had left home...would I look at tertiary study again, it's just too hard on the family. Helen

Theme 2: Professional self esteem

The participants reported changes in their practice following further education which included deeper understanding, being valued, autonomy, recognising leadership.

Depth of understanding: Professional self esteem

Three of the participants connected depth of understanding through under-taking post-graduate study with improved services and care for patients.

For Helen an expanded nursing role meant working to the full scope of her current practice nursing role:

It means working doing more nursing work beyond the basic expectation of a practice nurse – more than just dressings, more than just the vaccinations. Helen

And questioning why she did things:

I think in terms of changing my practice, it was getting rid of that way of doing things just because you always had. I think questioning more about why you did things. Helen

Anne identified opportunities for expanded roles within current general practice programmes:

I think there is starting to be more evidence to show the positive aspects for nurses ...in expanded practice...nurse led clinics, nurse led programmes like CarePlus, diabetes care, outreach nurses attached to practices in community.
Anne

Anne identified greater depth to her practice through utilisation of evidence-based-practice and frameworks following post-graduate study:

The reason I chose to do it (PG study)... I was working in chronic care...I wanted to provide a better consult for my patients... I have probably got more of an understanding of frameworks, I knew they were there, I read them, I read evidence based practice, but I hadn't put it into practice until I did the papers, so that was really positive. Anne

Claire related integrating theory to her practice following post-graduate study:

...when I have done some papers I've been able to apply that to my work... for example, why a person may be on a certain medication and why you need to monitor it in this way... then when you have a patient in front of you, you can explain a lot more easily... because you have a theory behind it. I can do a much better job when I have got that background knowledge in what I am doing. Claire

Conversley Claire noted that integrating theory to practice is not the case for other nurses she has spoken to:

A few nurses that have been nursing for many, many years and they just haven't got the desire to find out why they might do something or not do something...or why they are doing that procedure...Claire

Being valued: Professional esteem

All four nurses spoke about the changing role of practice nurses and feeling more valued:

Anne and Claire both spoke about the historical perception of nursing and the practice nurse role:

The role of the practice nurse...has changed. We used to be glorified receptionists...we were viewed as the lifestyle nurse...that's changing, that's going to be really positive towards expanded practice, particularly in primary healthcare. Anne

...a lot of it (practice nursing) was learning it on the job. Claire

I think that through history there was no expectation of nursing as a career. It's now a career...you are not just a female carer anymore, you are actually a professional... attitudes have to change and I think that the old school nurses who are really, really experienced but haven't got around to up skilling I don't actually see a lot of opportunity to continue that way of thinking. Anne

Jill identified the role of nurses working at an advanced level:

As nurses we are certainly doing an assessment at an advanced level. ...in some cases we do a lot of triage for the doctors. Jill

Helen spoke about job satisfaction and feeling valued:

I think this is the longest job that I have ever had... and it really is job satisfaction in terms of that really interesting work, really feeling valued...Those things are really important to be able to expand your practice Helen

Conversely Jill reported practice nurses are under-valued given their level of experience and requirement for further study:

...as a practice nurse we are undervalued...we should be rewarded for the level of study that we do...our experience... if we were given that opportunity the nurses would be happy about that. Jill

Helen felt valued through having her own work space:

...I have my own independent work space, have my own examination room, have the resources and facilities that I need. Helen

Anne spoke about public perception and the professionalism of nurses:

... the public have much more awareness now that we are professional... the public view is hugely important... Anne

Two nurses identified the positive aspects of the changing role of nurses in relationship to the general practitioner role:

...we have always been encouraged in our General Practice to expand our roles and to learn more... Claire

GPs are becoming better(at getting nurses to do more) and being happy for nurses to do more...GPs can't do it all, so the opportunities are becoming more and more for practice nurses to step in there... Helen

Two nurses associated extra study with remuneration and 'being valued.'

Helen reported her husband suggested extra study should be commensurate with increased remuneration:

He (my husband) said are you going to get more money at the end of this (study)? – well no, what are you doing it for then? Helen

Jill linked years of practice nursing service with remuneration and feeling valued:

*I think that as a practice nurse we are undervalued and we should be rewarded for the level of study that we do, or our experience...I have been in practice nursing for twenty years... starting off at \$20.00 dollars per hour and now at \$28.00 dollars per hour I think nurses are worth a lot more than that, particularly at that advanced level, with the skills that we have.
Jill*

Autonomy: Professional self esteem

All four nurses talked about autonomy in both a positive and negative sense:

Jill recognised there is autonomy in nurses' existing scope of practice:

We have a lot more autonomy within our scope of practice...we have greater skills and experience. We have specialist roles, without diagnosis...we certainly are the first line of contact. Jill

Anne defined autonomy as 'self responsibility':

It includes self-responsibility to do that extra professional development... the future of primary healthcare nursing is directed more towards expanded practice, nurse led care to benefit yourself, the patient and the practice that you are working in within the community. Anne

Claire reflected some feelings about nurses not wishing to be autonomous and being happy to limit their role:

I think some nurses just want to do their job, earn the money and go home...

Claire

Both Claire and Jill used the term 'hand maiden' to describe some nurse's relationship with doctors in relation to nurse autonomy:

I've had a word with some of the other nurses...one of them feels that as nurses we are not doctors, that it is the doctors role to do those sort of things, prescribing and things like that..., so that's the traditional role of nurses that they are hand maidens for the doctors. Claire

...within some practices, nurses are still thought of as the hand maiden and they are not allowed to be given those opportunities to expand their nurse's practice, or to be more autonomous in their health care. Jill

Working in isolation was identified as an issue affecting professional self-esteem:

... it's not healthy to work in isolation all the time, which I had always done, I had always ended up, not by choice, but had always ended up in small practices, usually I was the only nurse. Helen

Leadership: Professional self-esteem

Three of the nurses talked about leadership as a component of expanded practice:

Anne made reference to the recognition given to her by other nurses because of her extra study and experience.

... because of my experience, and because my colleagues are aware that I have done some post grad study... then I do get that positive feedback from the team... because I am involved at a national level... I have had comments

over the years ... that you are doing a lot for us as well as yourself, so that was really, really nice. Anne

Helen recognized her role as a potential educator and mentor as being part of 'expanded practice.'

... I have had years, and years of experience and maybe I have a lot to offer... part of expanded practice is working with other nurses as an educator and a mentor... I hope that my confidence will come up and I maybe if I did a Masters I could get to that level where I could be a mentor. Helen

Claire and Helen identified leadership as being part of an expanded role:

We have always had one nurse who has always been... ahead of everybody else and she is now a Nurse Practitioner, she has always helped and been a good person to go to if you wanted to know about what you should do...
Claire

I don't think everyone needs to do a Masters, not everyone needs to be at that level of leadership. Helen

Anne related her past experience of receiving leadership, mentoring and support in general practice:

In the past...we got incredible support as practice nurses...we had a practice nurse mentor...she would pop in and see if we needed any help... or if we wanted to talk to her about any issues... a really good resource to have. Anne

Conclusion

The nurses interviewed for this research identified post-graduate education as a key component necessary to support the expansion of their practice nursing role. Those who had embarked on the study pathway recognised positive differences education, at post-

graduate level, made to their practice and to their sense of professional self-esteem. The nurses felt supported to pursue education by their employers and colleagues.

The MOH funding for post-graduate education, whilst appreciated, did not cover the extra expenses rural nurses incur because of the challenges of distance from the universities. Family commitments, professional isolation and lack of support from university staff are further challenges faced by rural nurses pursuing post-graduate education.

CHAPTER 5: DISCUSSION AND RECOMMENDATIONS

Introduction

Within this dissertation a review of the literature pertaining to practice nurse development over the past fifty years has highlighted some of the influences on progress and expansion of the role. The dissertation builds on the work of previous research by Finlayson et al (2009) when participants, working in primary care settings, were interviewed to ‘take the pulse of the sector’ five years after the implementation of the Primary Healthcare Strategy.

Five years on, findings from the interviews with the four practice nurses in this research affirm themes identified in the literature; that practice nurses play a pivotal role in the lives of our population, often under difficult and challenging circumstances. Recent developments since the implementation of The Strategy have increased the demand for nursing services within general practice, but capacity, capability and collaboration within the practice primary care team has, in many cases, remained unchanged. This research highlights future implications for clinical practice as general practice moves towards a more patient centered, integrated model of service delivery.

Implications for clinical practice

This small research study involving four practice nurses has highlighted opportunities and barriers affecting the expansion of the practice nursing role. Key themes have emerged that have the potential to guide future developments in general practice. The practice nurse role will continue to come under scrutiny with the move towards a ‘better, sooner, more convenient’ model of primary health care in an increasingly demanding and complex health environment.

The emergent themes from the interviews are further discussed in this chapter. They are; the importance of post-graduate education and the need to address both barriers and opportunities associated with accessing this; and the influence of enhanced professional self-esteem as a result of nurses expanding their practice. The experiences of the study participants are discussed and related to the findings in the literature review.

Postgraduate education

The need for nurses to ‘step up’ and embrace higher education in order to expand their practice is identified, both in the literature and within the findings of this dissertation. Finlayson et al (2009) describe this as ‘increasing capability’ of primary health care nurses by improving their skills, honouring their experience, and supporting their education which will assist to develop new models of care. The study participants identified the importance of skill-based short courses and ‘on-the-job’ training. They also recognised post-graduate education as an important enabler to empower nurses to ‘step up’ and keep abreast of current knowledge, especially within the increasingly demanding and challenging environment they work in.

Several reports cited in the study support the drive for higher education for practice nurses, with the most recent government report from Health Workforce New Zealand giving a very prescriptive recommendation; that an essential pre-requisite to becoming an expert nurse is the early engagement of new recruits into post-graduate study, following a minimum of two years experience in a primary care setting (HWNZ, 2010). The report states that “formal post-graduate sub-specialty education is crucial to the provision of optimal patient care delivered by a workforce with skills that match the complexity of demand” (p.39).

Funding

As was identified in the literature review funding for advanced study emerged as a sub-theme in both a positive, and negative sense within the research findings. The participants’ professional and personal aspirations to access post-graduate education were linked to this. They cited availability of government ‘vote health’ funding was helpful but that it did not fully support the other requirements of study when living in a rural area away from tertiary education providers. Traveling from rural areas to post-graduate courses for compulsory on-campus attendance, sporadic availability of relief staff to ‘backfill’ for study-leave, and the high cost and challenge of on-line papers were all cited as barriers to accessing post-graduate study for the nurses.

Funding barriers related to access were also reported in the Health Workforce NZ report. Although there has been a steady uptake of study by nurses since the MOH funding became

available in 2006, the total uptake of nurses working in primary care under-taking post-graduate study accounts for less than one per cent of the total nursing workforce, indicating continuing barriers exist for nurses to participate in further study (HWNZ, 2010).

Support

As well as issues related to funding, two participants cited lack of support from their university provider as a barrier to study. Studying from a distance, feeling unsupported by university staff and not having local support for assignment writing and academic mentoring were all challenges that needed to be faced by the nurses. As well as feeling geographically isolated due to distance from the university the nurses felt professionally isolated from the university. One participant stated her tutor showed no interest in her as an experienced primary health care nurse giving scant regard to her knowledge and skill. Another nurse expressed frustration about tutors not returning phone calls and being less than helpful with answering questions from a distance.

Generally, the nurses in the study felt supported to expand their roles by their general practitioner employers, and were encouraged to do further study. This is in contrast with earlier findings in several reports which cited barriers to nurses being able to expand their practice were their employer / employee relationship with general practice owners, and the capitation funding model which supports fee-for-service medicalised care taking precedence over nursing work.

The participants acknowledged several improvements had occurred since the advent of the PHO bringing with it a focus on population-based health priorities, health promotion and preventative care, largely the domain of nursing work. Population-based funding has increased opportunities for nursing work through programmes, such as Careplus and Services to Improve Access targeted programmes, increasing both work demand and an identified requirement for further education for the nurses implementing the care. The Ministry of Health funding for post-graduate study and PHO support providing locum nurses to 'back fill' for study leave has been welcomed and appreciated by the nurses.

As well as the increase of more defined roles for nurses within general practice the literature review revealed recent changes being forced within the 'better, sooner, more

convenient' doctrine of the current government. This has challenged the dominant medical model of primary health care and encouraged thinking about new models of care. Finlayson et al (2009) identify emerging collaboration with members of the primary health care team as an essential component of expanding care that can be achieved through respectful relationships and collaborative team work. The research participants identified with this notion citing improved job satisfaction came with their expanded, more autonomous role.

Family

The three nurses who had undertaken post-graduate study all expressed how stressful it was combining study with family life. They felt their families had been cheated due to the amount of time required to complete the requirements of the course. For all three nurses living long distances away from the tertiary provider meant being away from their families for block study days compounding feelings of stress. One nurse stated her post-graduate study experience had put her off further study although she really believed it was necessary and wanted to do more.

Carryer (2011) identifies with the stress caused by nurses combining study, family, children and work and asserts, with improved collaboration between medicine and nursing, there has to be a better way. She suggests combining study into nurses' everyday practice as part of their workload as an option which needs to be further explored, a concept that was also identified by one of the study participants.

Professional self-esteem

Post-graduate study is recognized as an important influence on the professional self esteem of nurses working in general practice. Carryer (2011) states that postgraduate education is transformational in developing "clinical competence and increasing a sense of professional identity and confidence" (p.78), and is the most important tool to achieving genuine collaboration within the multi-disciplinary team. Professional identity, professional confidence, inter-professional respect and trust in nurse-doctor inter-professional relationships are based on demonstrated professional competence by nurses (Pullon, 2008).

Enhanced professional self-esteem was an overarching theme which emerged from the data. Having deeper understanding, being valued, defining autonomy and recognising leadership were qualities the nurses in the study identified within expanded nursing practice.

Deeper understanding

The study participants reflected their recognition of the importance of on-going education, particularly post-graduate education, linking it with increased depth of knowledge, and challenging old ways of doing and thinking within the general practice environment.

The nurses, in varying ways, described practice nursing as a practical endeavour making healthcare available to people who may otherwise have challenges with accessing services. Through publically funded programmes the nurses can now offer ‘free-to-patient’ services, such as chronic care management, immunisations, cervical smears, cardio-vascular risk assessments and smoking cessation. The nurses in the study recognised this was crucial work requiring depth of knowledge and theoretical under-pinning and it was not just task focused. The nurses recognised the connection between having deeper understanding and being valued for their work by both patients and their professional colleagues.

Being valued

Being valued was viewed from both a positive and negative perspective by the participants. All four nurses interviewed spoke about feeling more valued in their current role, relating this to increased job satisfaction due to their more autonomous role, having their own space to work in, having clearer role parameters and being affirmed by their colleagues. They recognised respect given to them by their colleagues when they had pursued higher education, and they in turn identified key qualities and values in other nurses who were working in expanded roles.

On the negative side of ‘being valued’ two practice nurses reported feeling under-valued because of their low remuneration. Their feelings are supported by reports sourced within the literature review that identified significant pay inequity exists between practice nurses and their DHB counterparts (Clendon, 2010; Finlayson et al, 2009).

One of the nurses in the study has received an \$8 increase on her hourly rate over twenty years of service, from \$20 an hour to her current rate of \$28 per hour. This compares to the current rate of \$29.50 per hour for a DHB nurse employed for five years. DHB employed nurses have the ability to move through twenty-four steps, practice nurses have the opportunity to gain additional payments through two merit steps (see Table 10).

Autonomy

The review of literature in this study has identified a number of key government policies that have influenced and shaped practice nurse development.

The Practice Nurse Subsidy Scheme (PNSS), introduced in 1970, was intended to liberate practice nurses to take up a more patient focused role. It instead disempowered many nurses due to the funding being paid directly to their employer. The development of the practice nurse role at this time remained at the discretion of the practice owner. Many GPs utilized the role to support their own work rather than supporting the expansion of an autonomous nursing role. The disempowerment of practice nurses and confusion around their role continued into the 1990s when, along with other major health reforms, the guidelines for implementing the PNSS continued to support role confusion and power / authority differentials between general practitioners and practice nurses (Carryer et al, 1999).

The nurses in the study referred to nurses who were not interested in expanding their roles as ‘hand maidens’, and identified a past perception of practice nurses as being the ‘lifestyle nurses’.

The implementation of the Primary Health Care Strategy (2001) heralded the beginning of a shift of power within primary care service delivery. Nurses were to play a crucial part in enabling improved access to health care historically dominated by general practitioners (Cumming et al, 2005; Finlayson et al, 2009; MOH, 2001). The participants indicated the shift of power is occurring within their teams with all receiving support and encouragement from their GP employers to expand their role. Consequently, the nurses are taking on more responsibility for their own development, managing nursing work with targeted

programmes, such as Careplus and preventative screening, and are working more autonomously, gaining both confidence and skill.

Leadership

Clinical leadership is well recognised as being an essential component of team work with lack of leadership an identified barrier to the expansion of the nurse's role (Finlayson et al, 2009; Larson & Lafasto, 1989).

Three of the nurses talked about leadership as a component of expanded practice with one nurse making reference to the recognition given to her by other nurses because of her extra study and experience. Mentoring and coaching were viewed by the nurses as important qualities of their own leadership roles. These same qualities were recognised as being important to assist nurses undertaking study. Two of the participants suggested a useful leadership role model for future consideration would be a practice-based mentor, leader and coach to support both clinical practice and nurses' under-taking further study.

Limitations of the study

This dissertation is a small qualitative descriptive study submitted by a post-graduate student in partial fulfillment of the degree of Master of Health Science. Unlike a Masters thesis, dissertations are small research projects, time limited, involving a small number of participants, therefore the research has its limitations.

The dissertation involved four participants all working within the same geographical area in a rural location where the ethnic demographic of the population is 30% Māori. All participants are experienced nurses having worked as practice nurses for between nine and twenty years. Two nurses had completed a post-graduate certificate, one a post-graduate diploma and one had not under-taken post-graduate study. The four nurses identify as New Zealand European with two nurses born in countries outside of New Zealand.

The small number of participants, and the short timeframe for the completion of the dissertation, means the research is limited due to its size and duration. Other limitations

include; participants were interviewed once only; purposive sampling limited the representation of the wider practice nurse group; one of the recorded interviews was very brief due to a malfunction of the tape; and the identified ethnicity of the participants does not reflect the demographics of the population served.

The qualitative descriptive methodology used for the dissertation has its limitations. Large amounts of data obtained in the interviews included information connected to, but not directly related to, the research questions. This made the analysis difficult at times. If the research had been a more comprehensive thesis study rather than a dissertation this could have been addressed by either follow-up interviews or focus groups with other practice nurse participants.

To further explore the limitations of the research and ensure integrity four criteria considered to be 'gold standard' were used to ascertain rigour. They are credibility, transferability, dependability and confirmability (Whittemore, Chase & Mandle, 2001).

Credibility

Credibility refers to the extent to which research findings represent reality, or truth. It is the ability for the research participants to confirm the findings as being true to their experience (LoBiondo-Wood & Haber, 1994). To ensure credibility in this study the transcribed data was returned to each of the nurses following the interviews with an invitation to edit the narrative if they desired. The transcripts were sent with a stamped addressed envelope to enable ease of return. Three out of four of the transcripts were returned with some minor changes that were then inserted into the transcripts and saved on a data stick. To further ensure credibility the data transcripts were printed, shared and discussed with my supervisor following the interviews which ensured guidance and oversight of the research process was maintained.

Transferability

Transferability refers to whether research findings can be applied to other groups, context and situations (Polit, Beck & Hungler, 2001). The protection of the nurses' identity is

paramount but it is important to give enough information to enable replication of the research at some other time.

The four participants are women working in the same discipline of nursing in general practice located within a rural primary health organisation. They all live at a distance from tertiary education providers. This information, along with the outline of the process for data analysis, is given in the report to enable readers to judge if the study could be transferred to other groups of nurses, or health professionals, in other contexts using the same method to analyse the data.

Dependability

Dependability in research is another way of demonstrating trustworthiness and is assessed according to the level of consistency of the research process with the research findings. Dependability is demonstrated by ensuring the method, methodology, sampling, data analysis and emergence of theory from the data is consistent with the method, and is stable over time (Polit et al, 2001).

In this study a descriptive exploratory methodology was used with purposive sampling. This methodology is appropriate because a straight description of the nurses' situation was required. Purposive sampling is a research method whereby practice nurse participants were sought for their common experience and 'day-to-day' reality. The dissertation contains a full description of the research methodology and methods used to collect the data. The analysis and interpretation of the data is given with a clear account of processes followed during the research. The literature review enabled the findings of the research to be contextualised within an historical perspective enabling deeper understanding of how past influences of practice nurse development has shaped the contemporary role. The findings of this research were found to be consistent and compatible with previous research about the phenomenon.

Confirmability

Confirmability refers to the objectivity and evaluation of the data, the ability to show connections between the data and the interpretation of the data. It is assured when the other

three criteria of credibility, transferability and dependability are met (LoBiondo-Wood & Haber, 1994). The use of notes used on the transcripts from the beginning of the analysis has assisted with achieving confirmability throughout the research process. Writing this dissertation has also allowed reflection on the research process at every stage. Discussions about the process with senior colleagues, and my research supervisor, have further assisted with assuring confirmability within the research study.

Areas for future research

New Zealand's primary health care environment is currently being driven by the government's 'better, sooner, more convenient' focus with a direction to create more integrated ways of working that are patient-centered, lead by clinicians, are cost-effective and have a focus on delivering health targets. Addressing disparities that exist in the current model of healthcare in New Zealand is of key importance, and one in which nurses must play a part.

This dissertation has explored the past and current role of the practice nurse with the aim to gain deeper understanding of both opportunities and barriers that exist to expanding the role of nurses to meet the future health needs of the New Zealand population. With the burgeoning burden of chronic disease, and the ageing population, it is essential to clearly articulate, strategise and plan how the new model of primary health care will develop, and what needs to be done to ensure opportunities are maximised.

Many areas of practice nurse development require further examination and research and are outside the scope of this dissertation. Capitation payments, the way the Ministry of Health funds most general practices, is one area that has a significant impact on whether nurses work autonomously in expanded roles (MOH, 2009). This is being examined at a national level under the government's drive to develop Integrated Family Health Centres.

The findings of this research have clarified some areas that require further exploration. The following are suggested strategies to support practice nurses to work in expanded roles within the emerging primary care environment:

Recommendations

Create more equitable access to post-graduate education for nurses who reside in rural areas. Nurses experience difficulties accessing on-site university courses from their rural homes. Options for ‘blended learning’ need to be explored that include combinations of on-line courses, local study tutorials, video-conferencing / skypeing from on-campus tutorials and local study peer groups.

Establish a ‘roving’ professional clinical / academic mentor role with joint accountability to the universities and local DHB / PHOs to support nurses undertaking post graduate studies in rural areas. As well as providing practical support the role would bring nurses together in study groups to address the isolation factors experienced by rural nurses.

Integrate requisite practice nurse ‘short courses’ (e.g. vaccination and smear training) into post-graduate study as part of a Postgraduate Certificate in Primary Health Care Nursing. The blending of ‘hands on’ courses with the theoretical underpinning of advanced study could attract more practice nurses into a post-graduate pathway of education.

Conclusion

The Primary Health Care Strategy set the direction for the New Zealand health system, signaling a focus on primary health care as central to improving the health of New Zealanders. Nurses were identified as being crucial to the successful implementation of The Strategy. For nurses working in general practice, as part of Primary Health Organisations, there have been many changes, challenges and opportunities since the PHOs inception in 2003. Although there has been some new funding for nurse work in general practice the capitation model of aligning patient funding to GPs has not always resulted in more autonomous work for practice nurses. It has increased the nurses’ workload and their quest to expand their practice but there are still many challenges to be faced before collaboration, capacity and capability of practice nurses is maximized.

The four nurses who participated in this research expressed many of the same frustrations expressed by primary health care nurses in previous studies. Barriers and opportunities to expanding their role are linked to funding in several ways. Funding is available, but limited, for post-graduate study opportunities for rural practice nurses. Protected, sustainable funding is needed to develop nurse led services that will increase their ability to work in expanded roles. Low pay rates for practice nurses, compared to other primary health care nurses, influences recruitment and retention, and affects practice nurses' professional self-esteem.

As the largest number of health professionals working in the health sector in New Zealand, nurses must meet the challenges of increasing demand from an ageing, increasingly unwell, culturally diverse population. At the same time they need to adapt to new models of care and the changing scope of traditional roles. The capacity for practice nurses to work in this changing environment, in expanded and more autonomous roles, requires close scrutiny. Careful forward planning and strong leadership is required if they are to build on the gains already made towards achieving a better, sooner, more convenient health service for all New Zealanders.

REFERENCES

- Ashton, T. (2009). *Evaluation of primary health care nursing*. Health Policy Monitor: University of Auckland.
- Baileff, A. (2000). Integrated nursing teams in primary care. *Nursing Standard*, 14 (48), 41-44.
- Black, S. & Hagel, D. (1996). Developing an integrated nursing team approach. *Health Visitor*, 67 (7), 280-283.
- Boyatzis, R. E. (1998). *Thematic analysis and code development: Transforming qualitative information*. California: Sage Publications Ltd.
- Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, (3), 77-101.
- Brown, C. (1992). *A study of the origins of the practice nurse subsidy scheme*. Research study for Advanced Diploma in Nursing at Auckland Institute of Technology. New Zealand: Author.
- Browne, K., Roseman, D., Shaller, D. & Edgman-Levitan, S. (2010). Measuring patient experience as a strategy for improving primary care. *Health Affairs*, 29 (5), 921-925.
- Burns, N., & Grove, S. (2001). *The practice of nursing research. Conduct, critique and utilization* (4th ed). Philadelphia: W. B. Saunders Company.
- Campbell, A., Gillett, G., & Jones, G. (2005). *Medical ethics* (4th ed.) Melbourne: Oxford University Press.
- Carryer, J., Dignam, D., Horsburgh, Hughes, F. & Martin, J. (1999). *Locating nursing in primary health care: a report for the National Health Committee*. Wellington: National Health Committee.
- Carryer, J. (2009). Un-named editorial. *Te Puawai. The Blossoming*. Palmerston North: College of Nurses Aotearoa.
- Carryer, J. (2010). Our obsessive restructuring. *Te Puawai: The Blossoming*. Palmerston North: College of Nurses Aotearoa.
- Carryer, J. (2011). Collaboration between doctors and nurses. *Journal of Primary Health Care*, 3(1), 77-79.
- Clendon, J. (2010). *2020 and beyond: A vision for nursing*. Wellington: NZNO.
- Colclough, P. (2008). *Health and social care integration. Care trusts: The Torbay*

- experience. Retrieved 5th May, 2010 from:
www.nuffieldtrust.org.uk/members/download.aspx
- Cooper, L. & Powe, N. (2004). *Disparities in patient experiences, health care processes, and outcomes: The role of patient-provider racial, ethnic and language concordance*. New York: The Commonwealth Fund.
- Crengle, S.; Lay-Yee, R.; Davis, P. & Pearson, J. (2005). *A Comparison of Māori and Non-Māori patient visits to doctors: The National Primary Medical Care Survey: 200 /02. Report 6*. Wellington: Ministry of Health.
- Cumming, J., Raymont, A., Gribben, B., Horsburgh, M. & Kent, B. (2005). *Evaluation of the implementation and intermediate outcomes of the Primary Health Care Strategy: First report*. Health Services Research Centre: Victoria University of Wellington.
- Davis, D. (2005). The professional practice of nurses in the general practice context. *The Practice Nurse*, 4(3), 17-18.
- Declaration of Alma-Ata (1978). *International conference on primary health care*. September 6-12, 1978; Alma-Ata, USSR: WHO/Europe. Retrieved on 2nd September, 2011 from: www.who.int/hpr/docs/declaration_almata.pdf
- de Montalk, J. (2010). *Polyclinics given the push from the top down*. Retrieved on 25th May 2010 from: <http://www.nzdoctor.co.nz/polyclinic>
- Department of Health. (2000). *Making a difference: Integrated working in primary care*. London: National Health Service (NHS) Executive
- Docherty, B. (1996). *Nursing in general practice: A New Zealand perspective*. Christchurch: Caxton Press.
- Docherty, B., Sheridan, N. & Kenealy, T. (2008). Painting a new picture for practice nurses in a capitated environment: who holds the brush? *The New Zealand Medical Journal*, 121(1284). Retrieved 4th October 2010 from: www.nzma.org.nz/journal/
- Doherty, G. (2011). Whānau Ora – a general practitioners perspective. *Best Practice: BPACNZ*, 37(14-15).
- Durie, M. (1998). *Whaiora: Māori health development*. Auckland: Oxford University Press
- Durie, M. (2004). *Exploring the interface between science and indigenous knowledge*. Christchurch: 5th APEC Research and Development Leaders Forum.
- Durie, M., Cooper, R., Grennell, D., Snivelt, S. & Tuaine, N. (2009). *Whānau Ora: Report*

of the taskforce on whānau- centred initiatives. Wellington: Report for the Minister for the Community and Voluntary Sector.

Finlayson, M., Sheridan, N. & Cumming, J.(2009). *Nursing developments in primary care 2001-2007.* Wellington: Victoria University of Wellington.

Ford, P. & Walsh, M. (1994). *New rituals for old: Nursing through the looking glass.* Oxford: Butterworth-Heinemann:

Foucault, M. (1980). *Michel Foucault. Power / knowledge: Selected interviews and other writings, 1972-1977.* Brighton, UK:Harvester Press.

Freeman, T. & Peck, E. (2007). *Adult care joint venture: Aspirations, challenges and options. A report for the integrated care network.* Birmingham: Health Services Management Centre, University of Birmingham.

Freire, P. (1972). *Pedagogy of the oppressed.* Hamondsworth: Penguin:

Fulton, Y. (1997). Nurses' views on empowerment: A critical social theory perspective. *Journal of Advanced Nursing*, 26, 529-536.

Gadamer, H.G. (1960/1982). *Truth and method.* (Barden & Cumming, Trans). New York: Crossroads.

Grant, B.M. & Giddings, L.S. (2002). Making sense of methodologies: A paradigm framework for the novice researcher. *Contemporary Nurse*, 13, 10-28.

Gray, B. (2005). Working on a salary for Newtown Union Health Service. *New Zealand Family Physician*, 32 (6), 372-374.

Gribich, C.F. (1999). *Qualitative research in health: An introduction.* St. Leonards, N.S.W: Allen & Unwin.

Halcomb, E.;Patterson, E.,& Davidson, P. (2005). Evolution of practice nursing in Australia. *Journal of Advanced Nursing*, 55 (3), 376-380.

Health and Disability Commissioner (1996). *The code of health and disability services consumers' rights.* Wellington: Health and Disability Commissioner.

Retrieved 4th August, 2010 from www.hdc.co.nz

Health Workforce Advisory Committee. (2005). *Strategic principles for workforce development in New Zealand.* Wellington: Ministry of Health.

Health Workforce Information Programme (2010). *Primary health care nursing*

workforce. Wellington: Health Workforce New Zealand.

- Hefford, M., Cumming, J., Finlayson, M., Raymont, A., Love, T. & van Essen, E. (2010). *Practice nurse cost benefit analysis: Report to the Ministry of Health*. Wellington: LECG
- Henty, C.M. (2005). *Practice nurses' experiences of the Care Plus programme*. Dissertation study for the degree of Master of Health Science, Auckland University of Technology. Auckland: Author.
- Hodgson, P. (2006). *Primary Health Care Strategy: Monitoring its achievement 2005*. Wellington: Office of the Minister of Health.
- Hudson, B. (2005). Sea change or quick fix? Policy on long term conditions in England. *Health & social care in the community*, 13(4), 378-385.
- Imison, C., Naylor, C. & Maybin, J. (2008). *Under one roof. Will polyclinics deliver integrated care?* London: The King's Fund.
- Imison, C. (2009). *Shaping PCT provider services. The future for community health*. London: The King's Fund
- International Council of Nurses (2006). *The ICN code of ethics for nurses*. Geneva: International Council of Nurses.
- International Council of Nurses (2011). *Closing the gap: Increasing access and equity*. Geneva: International Council of Nurses.
- IPAC (2002). Sustainable costing of general practice medical and accident services. Wellington: IPA Council of New Zealand.
- Jansen, P. & Smith, K. (2006). Māori experiences of primary health care: Breaking down the barriers. *NZ Family Practitioner*, 33(5), 298-300.
- Jansen, P. (2008). Disparities in care. *Best Practice. Improving Māori health*. May (13), 7-9.
- Jansen, P., Bacal, K. & Buetow, S. (2011). A comparison of Māori and non-Māori experiences of general practice. *The New Zealand Medical Journal*, 124 (1330);1-6.
- Kanter, R.M. (1993). *Men and Women in the Corporation* (2nd ed.) New York: Basic Books.
- Kearney, M. (2001). Focus on research methods. Levels and applications of qualitative research evidence. *Research in Nursing and Health*, 24, 145-153.

- Keleher, H. & Murphy, B. (2004). *Understanding health. A determinants approach*. Melbourne: Oxford University Press.
- Kent, B., Horsborough, M., Lay-Yee, R., Davis, P. & Pearson, J. (2005). *Nurses and their work in primary health care: The national primary medical care survey 2001/02 Report 9*. Auckland: University of Auckland.
- Klein, R. (2006). *The new politics of the NHS* (5th ed.). Oxford: Radcliffe Publishing.
- Larson, C. & LaFasto, F. (1989). *Teamwork: What must go right / what can go wrong?* 6(4), 368-73.
- Lightfoot, R., Davis, P., Finn, E., Lay Yee, R., Gribben, B. & McAvoy, B. (1999). Practice nurses in the Waikato, 1991- 1992, 1, occupational profile. *New Zealand Medical Journal*, 112(1081), 26-28.
- Little, P., Everitt, H., Williamson, I., Warner, G., Moore, M., Gould, C., Ferrier, K. & Payne, S. (2001). *Observational study of effect of patient centredness and positive approach on outcomes of general practice consultations*. Retrieved 3rd June 2010 from <http://www.bmj.com/cgi/content/full/323/7318/908>
- LoBiondo-Wood, G., & Haber, J. (1994). *Nursing research: Methods, critical appraisal, and utilization* (3rd ed.). Missouri: Mosby.
- Lovell, M. (1982). Daddy's little girl: the lethal effects of paternalism in nursing. *Socialisation, Sexism and Stereotyping: Women's Issues in Nursing*. St. Louis: Mosby:
- MacIntosh, J. & McCormack, D. (2001). Partnerships identified within primary health care literature. *International Journal of Nursing Studies*, 38, 547-555
- Manaia Health PHO, (2009). Annual Report. Whangarei: Manaia Health PHO Ltd.
- Manias, E., & Street, A. (2000). Possibilities for critical social theory and Foucault's work: A toolbox approach. *Nursing Inquiry*, (7), 50-60.
- Mel Pande, M., Stenson, A., Webber, C., Fretter, J., Fox, B., & Turner, J. (2006). *2005 RNZCPG Membership Survey: General Practice in New Zealand, Part 2: Future workforce intentions, teamwork and remuneration*. Wellington: Royal New Zealand College of General Practitioners.
- Michel, J. (1997). *Review of practice nurse services in the northern region*; unpublished report: Regional Health Authority.
- Ministerial Review Group. (2009). *Meeting the challenge: Enhancing sustainability and the patient and consumer experience within the current legislative framework for Health and Disability Services in New Zealand*. Wellington: National Ministerial Review Group.

- Ministry of Health (2000). *The New Zealand Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. (2001). *The Primary Health Care Strategy*. Wellington: Ministry of Health.
- Ministry of Health. (2002). *He Korowai Oranga: Maori Health Strategy*. Wellington: Ministry of Health.
- Ministry of Health. (2003a). *Investing in health: Whakatohutia te oranga tangata*. Wellington: Ministry of Health.
- Ministry of Health. (2003b). *Primary health care and community nursing workforce survey – 2001*. Wellington: Ministry of Health.
- Ministry of Health (2006). *Whakatataka tuarua: Maori health action plan 2006-2011*. Wellington: Ministry of Health.
- Ministry of Health (2007). *The evaluation of the eleven primary health care nursing innovation projects: A report to the Ministry of Health by the primary health care nurse innovations evaluation team*. Wellington : Ministry of Health.
- Ministry of Health. (2009). *Nursing developments in primary health care 2001 – 2007: A summary*. Wellington: Ministry of Health.
- Ministry of Health. (2010). *Trends in service design and new models of care: a review*. Wellington: Ministry of Health.
- Ministry of Health. (2010). *Clinical training agency nursing portfolio analysis: Postgraduate nursing funding 2007-2008*. Wellington: Ministry of Health.
- National Party (2008). *Policy 2008: Health – primary care*. Wellington: National Party.
- Neuman, W. (2003). *Social research methods: Qualitative and quantitative approaches* (5th ed.). Boston: Allyn & Bacon.
- New Zealand Government (1994). *Health and disability commissioners act*. Wellington: Government Print.
- Nursing Council of New Zealand. (2007). *Competencies for registered nurses*. Wellington: Nursing Council of New Zealand.
- Nursing Council of New Zealand (2010a) *Changes to the registered nurse scope of practice (expanded practice)*
Retrieved on 10th February 2011 from:
www.nursingcouncil.org.nz/index.cfm/6,5,0,0,html?criteria=expanded+practice

- Nursing Council of New Zealand (2010b). *The New Zealand nursing workforce*. Wellington: NCNZ.
- Patton, M. (2002). *Qualitative research and evaluation methods* (3rd ed.). California: Sage Publications Inc.
- Peterson, M. (2008). Practice nursing in New Zealand. *The New Zealand Medical Journal*, 121 (1285) Retrieved 4th October 2010 www.nzma.org.nz/journal/
- Polit, D.F., Beck, C.T., & Hungler, B. P. (2001). *Essentials of nursing research: Methods, appraisals, and utilization* (5th ed.). Philadelphia, PA: Lippincott.
- Primary Health Care Advisory Council. (2009). *Summary of the council's work to provide advice to the Ministry of Health and District Health Boards on primary health care service models*. Wellington: Primary Health Care Advisory Council.
- Pullon, S. (2008). Competence, respect and trust: Key features of successful inter-professional nurse-doctor relationships. *Journal of Inter-professional Care*, 22(2), 133-147.
- Ryall, T. (2007). *Better, sooner, more convenient: Health discussion paper by Hon. Tony Ryall*. Wellington: The Office of the National Party.
- Salas, E., Dickinson T. L. & Converse, S.A. (1992). Toward an understanding of team performance and training. In R. W. Swezey and E. Salas (Eds.) *Teams: Their training and performance* (pp. 3–29). Norwood, NJ: Ablex.
- Schoen, C., Osborn, R., & Trang Huynh, P. (2006). On the front lines of care: Primary care doctors' office systems, experiences and views in seven countries. *Health Affairs*, 25 (6), 555-71.
- Seaman, C. (1987). *Research methods. Principles, practice and theory for nursing* (3rd ed.). Sydney: Prentice-Hall of Australia Pty Ltd.
- Sheridan, N.; Finlayson, M. & Jones, M. (2009). Position statement: primary health care nursing. *Journal of Primary Health Care* (1), 2, 95-97.
- Skegg, P.D. & Paterson, R. (eds.) (2006). *Medical law in New Zealand*. Wellington: Thomson Brookers.
- Spence-Laschinger, H.K.; Gilbert, S.; Smith, L.M. & Leslie, K. (2010). Towards a comprehensive theory of nurse/patient empowerment: applying Kanter's empowerment theory to patient care. *Journal of Nursing Management*, 18, 4-13.
- Street, A.F. (1992). *Inside nursing: a critical ethnography of clinical nursing practice*. Albany: University of New York Press.

Sutch, B. (1941). Poverty and progress in New Zealand. A reassessment by William B. Sutch. Wellington: Modern Books.

The Kings Fund (2011). *Quality of general practice: Key findings for GPs from an independent inquiry*. Retrieved on 4th April 2011 from:
www.kingsfund.org.uk/gpinquiry

Tolich, M., & Davidson, C. (1999). *Starting fieldwork*. Melbourne: Oxford University Press.

Thomas L. & Ganster, D. (1995). Impact of family-supportive work variables on work-family conflict and strain: a control perspective. *Journal of Applied Psychology*, 80, 6-15.

Torrissis, D. & Hansen-Turton, T. (2005). *Community and nurse-managed health centres: Getting them started and keeping them going*. New York: Springer Publishing Company.

White, P.; Gunston, J.; Salmond, C.; Atkinson, J. & Crampton, P. (2008). *Atlas of socioeconomic deprivation in New Zealand, NZDep2006*. Wellington: Ministry of Health.

Whittemore, R., Chase, S. & Mandle, C. (2001). Validity in qualitative research. *Qualitative Health Research*, 11(4), 522-537.

Wilson, A.D. & Pearson, D. (2002). Barriers to developing the nurse practitioner role in primary care - the GP perspective. *Family Practice* (19) 6.

Appendix 1



Attention Practice Nurses!

One volunteer from your general practice is invited to participate in a research project:

PROJECT TITLE:

“Practice nurses’ perception of opportunities and barriers to the expansion of nursing roles within contemporary general practice.”

INVITATION

My name is Mary Carthew. I am a primary health care nurse. I am a student at Auckland University of Technology (AUT), Auckland. The research is a dissertation, which will be submitted to AUT in partial fulfillment of the degree of Master of Health Science.

As a Practice Nurse working in general practice you are invited to participate in this research. Participation in the research is your choice and you will not be advantaged or disadvantaged in any way.

WHAT IS THE PURPOSE OF THE STUDY?

The purpose of this study is to gain deeper understanding of the current role of practice nurses. It will examine existing opportunities and barriers which affect the expansion of the nursing role within general practice.

WHO ARE THE PEOPLE INVITED TO BE IN THIS STUDY?

Registered nurses who have worked in general practice for a minimum of 2 years have been invited to be part of this study. I seek ONE nurse from your practice. There will be three other nurses from different areas who will also be invited to participate.

WHAT HAPPENS IN THE STUDY?

1. If you choose to participate in this study I will firstly ask you to sign a consent form.
2. I will arrange a time for you to be interviewed by me, one-on-one, at a time and place which is convenient to you.
3. The interview will take approximately one hour, and with your permission, the interview will be audio-taped.
4. You will be asked 5 open ended questions
5. Following the interview the audio-tape will be transcribed by an independent typist who has signed a confidentiality agreement to protect your identity.
6. Once the interview is transcribed I will contact you to give you the opportunity to read the transcript and, if necessary, you can add or delete some of the data – you will have 4 weeks to respond to me with any changes to the transcript.
7. For your interest, when the study is completed, I will write a brief review of the study which I will send to you and the other participants.

HOW DO I JOIN THE STUDY?

If you would like to join the study please contact me before **21st April 2011**

RESEARCHER CONTACT DETAILS:

Mary Carthew
Manaia Health PHO
PO Box 1878, Whangarei
M 0212724072
P 09 438 1015
E mary@manaiapho.co.nz

Participant Information Sheet

Project Title:

“Practice nurses’ perception of opportunities and barriers to the expansion of nursing roles within contemporary general practice.”

Invitation

Thank you for your interest in this research. My name is Mary Carthew. I am a primary health care nurse working in a nurse leadership role within a primary health organisation (PHO). As a Registered Nurse with more than two years experience working as a practice nurse in general practice you are invited to participate in this research.

What is the purpose of the study?

The purpose of this study is to gain deeper understanding of the current role of practice nurses. It will examine existing opportunities and barriers which affect the expansion of the nursing role within general practice.

I am a student at Auckland University of Technology (AUT), Auckland. The research is a dissertation which will be submitted to AUT in partial fulfillment of the degree of Master of Health Science.

The research is supported and funded by the Chief Executive of the Manaia Health PHO, Chris Farrelly.

How are people chosen to be in the study?

Experienced registered nurses who have worked in general practice for a minimum of two years have been invited to be part of this research. Invitations to participate have been sent to Practice Managers to seek participants working in general practices. This method is known as ‘purposive sampling’ whereby participants are selected for their experience to enable an in-depth description of their experiences within a context, in this case within general practice. If you choose to participate in the research you will be one of four practice nurses who will be interviewed from 4 different general practices.

What happens in the study?

1. If you choose to participate in this study I will firstly ask you to sign a consent form.
2. I will arrange a time for you to be interviewed by me, one-on-one, at a time and place that is convenient to you.
3. The interview will take approximately one hour, and with your permission, the interview will be audio-taped.
4. You will be asked 5 open ended questions
5. Following the interview the audio-tape will be transcribed by an independent typist who has agreed to and signed a confidentiality agreement to protect your identity.
6. Once the interview is transcribed I will contact you to give you the opportunity to read the transcript and, if necessary, you can add or delete some of the data – you will have 4 weeks to respond to me with any changes to the transcript. A stamped

addressed envelope will be provided if you need to return the transcript with changes.

7. For your interest, when the study is completed, I will write a brief review of the study which I will send to you and the other participants.

What are the discomforts and risks?

Participation in the research is entirely your personal choice. You will not be advantaged or disadvantaged in any way. Prior to the interview both my supervisor and I will be available to discuss any concerns or questions you may have. During the interview you may experience emotions which you hadn't expected. This may cause you to become upset. If this happens you are free to withdraw from the interview and the study at any time up until the time the data collection is complete. Some of the experiences you share in the interview may be personal, and you may regret disclosing these experiences later on. If this happens you can contact me at any time and I can delete the information from the study - this can happen at anytime up until the time the data collection is complete. In the interview you will be asked questions in relation to your work as a practice nurse working in general practice. Sharing information about your experiences may cause feelings of discomfort in relation to your employment relationship with the general practice owner/s or your colleagues. If any aspect of the interview or study causes you distress, or if issues arise directly related to the research, I will provide free counselling (at no cost to you) with a counsellor of your choice. You have a right to withdraw from the study at any time.

What are the benefits?

Participating in this research provides an opportunity to contribute to the identification of impediments to nursing care delivery which can be considered when developing new models of care. Upon request I will provide you with a letter documenting your participation in the research which can be included in your professional portfolio.

How will my privacy be protected?

Your participation in the study is kept confidential by the researcher. Your name will not be used in any reports of the study. I will ask you to provide me with a pseudonym (false name) prior to the interview and this will be used in all your transcripts.

Because of the small number of participants in the study – there are four - and because the practice nursing community in Northland is relatively large – a pool of 140 nurses - the possibility someone will recognise some of your experiences within the study is small.

I will make available all the necessary equipment and a suitable venue to ensure privacy such as a private room for the interviews which is a neutral place away from your workplace; a locked filing cabinet for the transcripts to be stored; ensuring that all documentation about the research is anonymised and kept confidential; ensuring the computer used for the writing of the study is password protected; and ensuring the signed consent forms are always stored separately from the data. After completion of the study, my supervisor is required to maintain all information from the study in a secure place for 6 years. After 6 years it will be destroyed.

If you withdraw from the study your data will be destroyed immediately.

How do I join the study?

After reading this information and you decide you would like to consent to be part of this study please contact me at work, phone 09 4381015 or mary@manaiapho.co.nz to inform me of your willingness to participate.

Opportunity to receive feedback on results of research

A summary of the research will be shared with you prior to submitting the final document to AUT.

Queries and Concerns

If you have any concerns about the type or nature of the study please notify

Project Supervisor:

Dr Anita Bamford-Wade
Auckland University of Technology
Private Bag 92006
Auckland, 0251
(09) 921 9999 extn 7334
anita.bamford@aut.ac.nz

If you have concerns about your participation or the conduct of this study please call:

Executive Secretary, AUTEK

Madeline Banda
Phone: 09 921 9999 ext. 8044
Madeline.banda@aut.ac.nz

Researcher contact details:

Mary Carthew
Manaia Health PHO
PO Box 1878
Whangarei
Cell: 021 2724072
mary@manaiapho.co.nz

Many thanks for the time spent considering the opportunity to participate in this research.

This study has been approved by: Auckland University of Technology Ethics Committee (AUTEK).

Appendix 3



Consent to Participation in Research

Title of Project:

“Practice nurses’ perception of opportunities and barriers to the expansion of nursing roles within contemporary general practice.”

Researcher: Mary Carthew

-
- I have read and understood the information provided about this research project (Information Sheet dated 20th December 2006)
 - I have had an opportunity to ask questions and to have them answered.
 - I understand that discussions will be audio-taped and transcribed.
 - I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
 - I agree to take part in this research.
 - I wish to receive a copy of the report from the research: tick one:
Yes No

Participant signature:

Participant name:

Participant Contact Details (if appropriate):

.....
.....
.....
.....

Date:

Approved by the Auckland University of Technology Ethics Committee (AUTEK) Committee on: 17/03/2011

Note: The Participant should retain a copy of this form.

Appendix 4

“Practice nurses’ perception of opportunities and barriers to the expansion of nursing roles within contemporary general practice.”

Interview questions:

1. What is your understanding of expanded nursing practice?
2. What are the opportunities to make this happen?
3. What are the barriers to implementing expanded nursing practice?
4. How can some of the identified barriers be overcome?
5. What professional development is required to support the development of expanded practice for practice nurses?