February 2004

The Inaugural National Practice Nurse Conference

Final Report

BACKGROUND

The report is structured according to the main themes of the conference, and is intended to convey some of the more relevant and interesting presentations at this conference. It also contains a concluding summary. Unfortunately, due to the concurrent session format of much of the conference, not all of the presentations can be reported.

OFFICIAL OPENING

Approximately 120 delegates gathered at the Bunbury Conference and Entertainment Centre for a moving Nyoongar welcome by **Joe Northover**, a traditional custodian of the land.

Claire Caesar, Australian Government Department of Health and Ageing acknowledged practice nurses as an important component of primary care reform in Australia, no longer the "poor cousins of the nursing profession". Interesting points:

- The Commonwealth will provide funding to the Australian Practice Nurses Association (APNA) ($422,400 over two years) in order to help them develop the organisation and to support local level networks of practice nurses. The funding will enable APNA to employ an Executive Officer in 2004
- The "dedication and innovation" of the Demonstration Divisions was acknowledged
- Funding has been provided through the National Steering Committee to the Australian Nursing Federation (ANF) to develop competency standards for practice nurses.

KEYNOTE ADDRESSES

Dr Elizabeth Patterson, Griffith University reported on her extensive research around practice nursing in Queensland. Findings included:

- 60% of GPs surveyed didn't employ registered nurses (akin to the national average)
- Average practice nurse: female, 42 years old, a lot of acute experience and often a background in midwifery
- Currently, roles are mostly task-orientated, medically prescribed, and general. Therefore, the scope of nursing practice is determined by roles rather than by knowledge or expertise. Interventions are usually opportunistic rather than planned.
- 21% of the GPs with a nurse and 36% of those without a nurse believed that receptionists could be trained to perform many nursing roles. About 50% had non-medical staff performing nursing roles.
- Challenges: general practice is medically dominated and this is supported by the financing system; nurses are accommodating and often passively accept limited roles due to loyalty to the practice and the business; nurses often value lifestyle benefits over career opportunities; few nurses have advanced health promotion training.

June Smail, University of Wales, United Kingdom was and is a pioneering practice nurse in the UK. The first UK national practice nursing conference was held in 1983, when there were only around 3000 PNs in the UK; there are now 20,000. Interesting points:

- It was the introduction of GP contracts in the UK that led to a large increase in the number of nurses employed. GPs were subsidised up to 70% for the employment of a nurse, and their contracts specified that they had to reach certain population health targets
- By the early 1990s there were various Diploma courses for PNs based on specific competencies
- The Damant Report in 1990 showed that the role of the PN was underpinned by complex cognitive and procedural *processes*, not just tasks
- After intensive lobbying, three PNs were elected to the national registration body (UKCC) for the first time in 1993
- Grades of practice nursing were developed: D&E for new PNs, F&G for specialist PNs, and H&I for nurse practitioners or consultant nurses. The consultant nurses were involved in teaching and researching roles
- Specialist PNs supervise new PNs, and tend to be specialists in several areas eg: running an immunisation clinic from 9.00-10.30, then going and running a the well-woman's clinic from 10.30-midday, whilst the D&E nurse performs more generalist tasks and takes care of stocks, infection control, wound dressings etc
- A "Toolkit for PNs" was developed and disseminated
- A few PNs are employed by Primary Care Trusts, but most are happy to be employed privately
- There is still an unequal power base, but many nurses are okay with this
- The evolution of interdisciplinary education has really driven teamwork

Dr Bruce Lervy, University of Wales, United Kingdom spoke of the new responsibilities that practice nurses will ultimately have to take on due to the increasing demands on health services. Traditional roles will begin to be usurped as nurses in primary care become partners in care teams. He spoke of the importance of having functional teams in practice:

Functional Teams	*Dysfunctional Teams*
• Unique skills are respected • Corporate respect • Well structured team meetings • Task-led leadership • United image • Participatory • Clear purpose / vision • Trust - self-knowledge and competence	• Work individually and/or in isolation • Infrequent meetings • Informal meetings • Heirarchical • Opinions ignored • Variable performances

RESEARCH

Ann Salmons, East Bentleigh Medical Centre spoke about the evaluation of a nurse-led asthma clinic in her practice. The practice has five partners and three part-time doctors. The content for the clinic is based on the 3+visit methodology, and involves at least two 45 minute sessions with a nurse, and involvement from the doctor. The study was based on a mail-out survey, posted to participating patients after the second consultation. It looked to evaluate the impact of the asthma clinic on patient knowledge of asthma, changes in self-reported asthma management, and satisfaction with the clinic. Thirty-seven out of fifty responses were received. The results were as follows:

- 80% gave correct answers to knowledge items (device use, what asthma is, aim of the plan etc);

- 75% agreed that they paid more attention to inhaler techniques and were more likely to attend the practice for a routine review; and
- 91% were satisfied with the clinic.

Ms Salmons concluded that the GP-nurse partnership approach to asthma management has worked well, has a high level of patient support, and is financially viable.

Lorinda Schultz, University of Newcastle reported on a study of doctor/nurse teams in rural and urban general practice in the Hunter Valley area. She found that the initial employment of nurses was to "plug a gap" but that the nursing role would subsequently expand, particularly in maternal and child health.

- *In practices without a nurse*, reasons for not wanting to employ a nurse were cost, lack of physical space, concern about litigation, and concern about GP de-skilling. More often than not, these practices had closed books and/or long waiting lists (up to two months).
- *In practices with a nurse*, GPs felt they were offering a better service and were more able to deal with patient demand. They seemed to be less stressed and the flexibility of having a nurse was valued.

Dr Jane Smith and Gillian Foster, Inala Health Centre of General Practice reported on the (unfunded) establishment of an "Evidence Based Practice Club" (EBP Club) in their practice. The practice has 10 GPs and 6 nurses, all part time. The GPs and nurses meet every 1-2 weeks over lunch to discuss one or two crucial clinical questions. A question is posed and the group brainstorms, then searches the Cochrane database to establish what constitutes evidence-based care. 31 out of 56 of the EBP Club questions led to change in the way patients were treated. Questions included:

- Should all diabetics be on aspirin? (yes)
- Do pedometers really help for diabetics? (yes)
- Which diabetics really need to see a podiatrist, given that there are long waiting lists? (only those who are at high risk or already showing problems)
- Can urine testing be used as a substitute for skin-prick testing? (yes)(controversial)

Relating to diabetes care, the questions have led to nurse-led reform in the practice. Nurses in the practice have since made sure that there are adequate stocks of pedometers and monofilaments; have changed diabetic e-templates; and have decreased the frequency of diabetic check-ups to quarterly. Dr Smith and Ms Foster also reported on moving from GP immunisation to nurse immunisation in the practice. The change meant that the waiting time for an immunisation dropped from 27 minutes to ten minutes. Most consumers were happy with the change, but 8/41 patients were not. The other barrier to a sustainable service was the lack of MBS rebate for nursing immunisation.

ROLE EXPANSION

Merilyn Annells, La Trobe University spoke about the evolution in the way that nursing actions are guided. Traditionally in nursing, actions have been guided by formal training, expert opinion, personal experience, trial and error, intuition and conjecture. However, nurses are increasingly specialising with specific foci on particular disease categories – for example, diabetes, asthma. In the 21st century, nurses need to be more focussed on systems and evidence (eg Cochrane, NHMRC).

Julie Porritt, ADGP facilitated a workshop examining some of the challenges faced by the practice nursing profession in driving the future development of the role for practice nurses, and in promoting practice nursing as a career choice. Workshop participants identified the following elements as important in the quest to increase the profile of nursing in general practice:

- Recognised training programs need to be developed to meet the specific training/education needs of nurses working in general practice;

- Current practice nurses need to step forward and become leaders, sharing their knowledge, skills and enthusiasm and contributing to the development of the profession;
- Undergraduate nursing students should be offered an opportunity to undertake a clinical placement in general practice in order to experience first hand the interesting, challenging and rewarding opportunities that are available to nurses working in this area;
- General practice staff including nurses need to promote the role of the practice nurse to consumers through promotional material at the practice and through local media – newspapers, radio and television;
- General practice nurses need to recognise and understand their professional responsibilities to participate in ongoing education and training; to practice within their scope of practice and competence; and to uphold the Code of Ethics and Code of Professional Conduct for Nurses; and
- Performance appraisals systems should be in place at the practice to ensure that practice nurses are given an opportunity to reflect on their nursing practice and to identify opportunities for further development and enhancement of their role.

Tanya Bubner, University of Adelaide formed a focus group (PN, GP, PM, consumer, allied health professional) to investigate the question "What factors inhibit the expansion of the practice nurse role in chronic disease management in general practice?"

Nurse Issues	Practice Organisation Issues	Way Forward
• Poor pay • Lack of funding (no item numbers) • Sometimes too many roles for nurse • Lack of support and understanding	• Not valuing the nurse • GPs hesitant to delegate patient care to nurse • Practice meetings don't always involve PN • Lack of staff development • Lack of team approach	• Clarification of roles and responsibilities • Mutual respect • Acceptance of PNs within GP culture • Support for ongoing education • Division of GP to include nurses in activities • Divisions to show how PN role can be best utilised

EDUCATION

Vicki Drury, Edith Cowan University spoke passionately about catering for the education needs of rural nurses. She spoke of the need for education to be relevant to the nurse, practice and patient, as well as being accessible, affordable, relevant and flexible (eg options such as distance education, e-learning, residential schools to increase access).

Christine Prosser, Canning Division of General Practice focused on the "tug of war" between professional standards (duty of care, ethics, safety) and practice demands/priorities. Her presentation concluded that there needs to be somebody educating GPs about PN competency standards, ethical responsibilities and professional development needs.

CLINICAL PRACTICE

Elaine Green, Leschenault Medical Centre, WA showed how the nurses in that practice had been catalysts for change. In order to identify more patients with Type 2 diabetes in the practice, the nurses made July 2003 "Diabetes Screening Month". There was a marketing campaign in the practice, with receptionists asking patients if they wanted to participate. 87% of patients who were asked to participate agreed, and were then screened.

Liz Meadley, Hunter Urban Division of General Practice and the University of Newcastle reported on her study of practice nurses within the Division. The study included two surveys of practices (2000 and 2002), a literature review, questionnaire and focus groups. Findings:

- 60% had job descriptions (46% felt the job descriptions reflected actual roles)
- 28% were paid $19-$21 per hour and 29.6% paid $25-$27 per hour
- 2003 workshops: 56.3% were paid for by the practice
- Education needs identified: CPR, infection control, cultural diversity training, child protection, health promotion

The Division's 2004 workshops will focus upon a systemic approach to the implementation of EPC and PIP.

Dr Allan Kirkpatrick, GP and Board Member of the Hunter Urban Division of General Practice gave a presentation about the process of employing a nurse, and the subsequent expansion of the services provided by his practice. Initially, a nurse he knew from his hospital days approached him. This nurse was looking for part time work. A very rough cost-benefit analysis showed that the nurse would cover her own wages by performing 4 health assessments within her 20 hour week, with time left over for other duties. The role expanded immediately to wound care (where he believes nurses provide a superior service) and then to immunisation, infection control, and managing the accreditation process. The practice moved to larger premises and employed another nurse. The nurse roles expanded again, to include corporate vaccination (influenza), coordination of care plan processes, pre-employment medical checks, and pap smears. In conclusion, Dr Kirkpatrick said

- Funding of general practice *must* include practice remuneration for specific nursing services
- Nurses managing chronic disease would do a better job than GPs, because the GP does not have the time for those long consultations
- GP attitudes toward nurses are variable – some may have had negative experiences in hospitals, and carry a grudge
- Nurses must be able to add to the business as well as patient care
- Nurses possess unique skills which differ from and compliment those of the GP

COLLABORATION

Shauna Gaebler, Perth and Hills Division of General Practice presented the Division's Practice Nurse Modelling Tool. The tool is similar to the Hunter Urban Division's financial modelling tool (available for Victorian Divisions through GPDV since 2002), except it is a little more complex, sophisticated and time-consuming. The tool helps practices to determine how much money the practice could make by employing a practice nurse, or how much GP time could be saved without decreasing service to patients. The Division is trialing the tool.

Sue Ramsey, President of the Royal College of Nursing Australia (RCNA) stressed that nurses accept an obligation to maintain their competence and to strive to improve themselves through professional development activities, including ongoing education. She affirmed the College's commitment to help PNs do this by providing access to high quality education. Presently, the College is preparing a funding submission for educative scholarships for practice nurses. The joint education program with GPEA will continue in 2004, with more workshops, particularly in rural/remote areas.

Tessa Pascoe (RCNA) and Ronnelle Hutchinson (RACGP) presented on their joint project looking at the education that has been provided to PNs and where the "gaps" are. Unfortunately, they could not discuss any of their findings because the report had only just been submitted to the Commonwealth. They specifically thanked Divisions for being so forthcoming with assistance.

PLENARY PANEL DISCUSSION

- There was a general agreement that the financing of general practice needs reform in order to facilitate the expansion of nursing roles in general practice
- The Department of Health and Ageing's representative expressed reservations about the establishment of specific MBS item numbers for practice nurses, but asked that nursing and GP organisations put their thoughts on paper
- There were calls for nursing organisations to work in partnership rather than in competition, and to include other primary care nurses in planning (eg RDNS)
- There were calls for nurses to gather at the grass-roots level to network, and feed into policy development at the national level
- GPDV spoke about the work of divisions in helping coordinate education and practice nurse networks and suggested that the networks could be run in partnership with APNA, who has an objective to provide local level support to nurses. This is something for divisions and APNA to consider in 2004, particularly if the end of CDM funding threatens the viability of PN networks.
- RCNA proposed that there be a second national conference. GPDV suggested that practice nurse networks could nominate one nurse to attend from each division. A second conference has now been announced and will be held in Wollongong, 21-23 October 2004.

CONCLUDING REMARKS

It was an interesting first conference. There was a strong focus on research, particularly around role expansion. The keynote speakers gave excellent presentations. June Smail showed exactly what would need to happen in Australia if we wanted to go down the UK path. Dr Kirkpatrick's presentation showed how GPs may be convinced to employ a nurse, with nursing role expansion occurring naturally as the GP realises the opportunities that having a practice nurse presents for the practice. The conference highlighted some of the issues that need to be addressed and in this sense, it was a success.

Disappointingly, there was no research presented on patient outcomes as a result of nursing interventions, probably because Australian research analysing the outcomes of practice nursing interventions is in its extreme infancy. Also, there was no agreement about what the distinct roles of the various nursing organisations in Australia should be, and no representation by the nursing councils / boards as far as could be ascertained. The review of EN/Division 2 nursing competencies was not discussed, nor was supervision or insurance issues for practices. Finally, collaboration with general practice organisations in the development of practice nursing roles was only touched upon. Given that the majority of the audience was practice nurses, perhaps some of these organisational issues should be discussed in a national forum involving GPs. This discussion actually did begin during the nursing session at the 2003 Australian Divisions of General Practice Forum.

Overall, the prospects for practice nursing in Australia seem very bright. It seems that the speed of the development of practice nursing roles in Australia may rely heavily on two things:

- the way that the Australian Government chooses to remunerate general practice in the 21st century, and
- the extent to which the Government subsidises the employment of nurses by general practices.

The way that nursing representative organisations work to provide the necessary structures and opportunities for practice nurses will also be crucial. This work will determine whether the vast majority of Australian practice nurses have the necessary incentives to pursue ongoing professional development opportunities.