

2009



# Australian Practice Nurses Association Submission: National Primary Health Care Strategy Discussion Paper



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## WHO ARE WE

The **Australian Practice Nurses Association** (APNA) is a professional association run *by* practice nurses *for* practice nurses. It provides representation, support and professional development for practice nurses at national, state and local levels.

Prior to APNA being formed, there was not a formal support network for nurses working in general practice. APNA was incorporated on the 10th August 2001, and our first National Executive was elected on the 16th August to represent and promote the interests of practice nurses by developing and maintaining networks with key stakeholders. Subsequently we received seeding funding for 3 years from the Department of Health and Ageing in recognition of the need for such an organisation. Whilst now funded primarily by member subscriptions, we continue to administer the Department of Health and Ageing's *Continuing Professional Development for Practice Nurses* program, comprising provision of over 2000 professional development and postgraduate scholarships to practice nurses as well as development of online learning opportunities.

In 2009, we are now a vibrant and dynamic association with over 1500 members and growing, and regular contact with many more practice nurses through our workshops, website and other activities. We provide nurses with a voice in policy decision making about this fast evolving role, access to range of specific information, resources and education, as well as tools for ensuring practice nurses practice professionally e.g. CPD program and professional indemnity.

## CONSULTATION PROCESS

Our submission was developed using a range of consultation methods to ensure that the views expressed within this document reflect the experience and knowledge of nurses in general practice and experts in primary health care. Our consultation processes have included:

- a. Canvassing APNA members for their input on what is working in their setting, what is not working and what was their key priority area for change
- b. Consultation with the members of our Policy and Research Committee who comprise the following and are tasked with advising the APNA Board
  - a. Carmen Pearce-Brown, RN, PhD Candidate, APNA board member
  - b. Kevin Pittman, APNA co-opted board member
  - c. Judy Evans, RN, APNA member and ex-APNA President
  - d. Professor Elizabeth Patterson, Head, School of Nursing and Midwifery Gold Coast Campus, Griffith University
  - e. Dr Elizabeth Halcomb, Senior Lecturer, Course Coordinator Grad Dip / Master of Nursing, School of Nursing and Midwifery, University of Western Sydney
  - f. Dr Catherine Joyce, Department of Epidemiology and Preventive Medicine School of Public Health and Preventive Medicine Monash University

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- g. Associate Professor Meredith Temple-Smith, Primary Care Research Unit Department of General Practice University of Melbourne
- h. Dr Rhian Parker, Associate Professor, Australian Primary Health Care Research Institute
- c. Discussion and agreement between APNA board members
- d. CEO canvassing key stakeholders from medical peak bodies, peak nursing bodies, allied health groups and commercial stakeholders such as pharmaceutical companies and education providers

## GENERAL PRACTICE NURSING

General practice nurses are the fastest growing specialty of nursing in Australia and practice nurses numbered around 7,824 (est.) in 2007, presenting an increase of 59% from 2005.<sup>1</sup> More than 60% of practices have a GPN and their roles include prevention (immunisation, pap smears, sexual health screening, life style risk factor monitoring and counselling and more), chronic disease management (monitoring, care planning, care coordination and self management support), triage, minor injury management, health assessments, quality improvement and other diverse activities. Over 10 million Medicare item numbers involving practice nurses have been claimed in the last 4 years. A comprehensive analysis of the general practice nursing specialty is provided in the 2007 Parliamentary Report.<sup>2</sup>

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## INTRODUCTION

APNA welcomes the development of a national primary health care strategy as a key step towards ensuring all Australians have access to affordable, high quality primary health care services which meet their needs. The principles proposed by the Discussion Paper comprehensively cover the issues that need to be addressed and we would not be suggesting any further areas. We also agree with the need to focus on ensuring greater equity not only in access to services, but also in health outcomes for all Australians, and on delivering a primary health care system where accountabilities for performance and outcomes are more transparent.

We wish to provide some overall comments prior to addressing the questions posed in the Discussion Paper in more detail.

We strongly support the focus on primary health care but as nurses, are very conscious that primary health care is substantially more than the general practice context. We acknowledge that there are more nurses working in primary health care settings away from general practice than within, such as school nursing, maternal child health, occupational health nursing, community/home visiting nursing, prison nurses, drug and alcohol nursing, public immunisation nurses, family planning and sexual health nurses to name but a few. We will be largely restricting our detailed comments to the contribution and impact of strategies on general practice nurses but wish to stipulate that a primary health care system that recognises and integrates these nursing services into a broader primary health care strategy would enable the nursing contribution to primary health care to be strengthened.

In addition, we would like to emphasise the natural fit between nursing and primary health care. As Australia's largest group of health professionals, nurses are educated to practice collaboratively to provide clinical care which embraces a holistic approach to patient care.

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*“Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles.” International Council of Nursing*

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The specific domain of nursing is people's responses to and experience of health, illness, frailty, and disability, in whatever environment or circumstances they find themselves. The term “people” includes individuals of all ages, families and communities, throughout the entire life span. Their responses may be physiological, psychological, or social, and will usually combine all three.

The purpose of nursing is to promote health, healing, and normal growth and development; to prevent illness; and, when people become ill, to minimise distress and suffering, and to enable them to understand and cope with their disease, its treatment and its consequences.

Nursing practice is an intellectual, physical, emotional, and moral activity. It is based on ethical values which respect the dignity, autonomy and uniqueness of human beings, the privileged nurse patient relationship, and the acceptance of personal accountability for decisions and actions. It includes the

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identification of nursing needs; therapeutic interventions and personal care; information, advice and advocacy; physical and emotional support; management, policy and knowledge development.

Nurses work in partnership with patients, their relatives and other carers, in collaboration with others as members of a multi-disciplinary team. Sometimes they will lead the team, prescribing, delegating and supervising the work of others as appropriate; at other times they will participate under the leadership of others. At all times, however they remain personally accountable for their own decisions and actions. <sup>1</sup>

Many of the core principles contained within these definitions of nurses demonstrates why nurses are so critical in the delivery of primary health care.

Finally we would like to see clarity in any final strategy document around primary health care versus primary care and how the two intersect. We are attracted to the proposals from the National Hospital and Health Reform Commission for primary health care to be funded by a single funder, the Commonwealth, and for comprehensive primary health care centres which encompass a range of primary health care services in addition to general practice. We see there is much to be gained by nurses working within a multidisciplinary team but also within a nursing team of nurses with different primary health care skills such as school nursing, maternal child health, home visiting nurses etc. This will provide access to not only comprehensive primary health care but comprehensive nursing care for consumers at all ends of the life and health spectrum.

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1. AUSTRALIANS SHOULD HAVE ACCESS TO PRIMARY HEALTH CARE SERVICES WHICH KEEP PEOPLE WELL AND MANAGE ILL-HEALTH BY BEING ACCESSIBLE, CLINICALLY AND CULTURALLY APPROPRIATE, TIMELY AND AFFORDABLE;

General practice nurses are a flexible generalist workforce and hence an ideal workforce for deployment across a range of areas, population groups and service types, thus increasing access to patients. Furthermore nurses have been shown to be an affordable cost effective workforce.

In the recent National Hospital and Health Reform Commission Interim Report, nurses were found to be the only health workforce who are currently distributed throughout rural and remote areas.

APNA believes that access to nursing care should not be restricted by billing structures which require a GP to be present (see feedback in box)

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### **Feedback from a rural practice nurse**

*I would just like you to "spell" out the implications of what is meant by "supervised" delegated role with this classic example in my community recently.*

*There were 2 GP's on in the town, each one practicing out of a different practice, both supported by dedicated practice nurses. On the day that both GP's were too ill to attend their respective surgeries, they were fully booked and so were the practice nurses. Not only were the residents of our village denied any local emergency care that day, all the patients booked for the doctor and the practice nurse were cancelled.....why????...because there were no GP's at the surgery for the Medicare billing!!! If these clients were in a hospital bed the doctor might see them every day or two and leave orders for the nurse....what is the difference?? Surely having phone orders for medication, radiology and path, and referrals to allied health, just like the hospital protocols would suffice.*

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2. AUSTRALIANS SHOULD HAVE ACCESS TO PRIMARY HEALTH CARE SERVICES WHICH KEEP PEOPLE WELL AND MANAGE ILL-HEALTH BY BEING PATIENT-CENTRED AND SUPPORTIVE OF HEALTH LITERACY, SELF-MANAGEMENT AND INDIVIDUAL PREFERENCE;

Nursing is by its own definition patient centred with nursing problems being identified in terms of the patient experience of their health needs. Hence nurses are ideally placed to partner with consumers on their health journey.

APNA supports incorporation of patient/consumer input into all aspects of health care delivery, design and governance. Clinical care in the general practice setting should be responsive to and informed by patient satisfaction input into nursing care as well as medical care and currently there is no patient satisfaction instrument for nursing care in general practice.

APNA recommends that patient satisfaction be sought for services provided by all clinicians in the general practice setting and used to inform service improvement.

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*Leone Dunn from Gynea Medical Practice in Sydney won the APNA Servier Best Practice Award for Innovation and Commitment to Nursing in General Practice. Lee identified that many elderly residents she was providing chronic disease management for were lonely and socially isolated and many others failed to regularly exercise due to their various fears. As exercise was an important part of maintaining their health, particularly those with osteoporosis and heart disease, Lee set up an ongoing regular weekly walking club. After needing to go to a coffee shop one day due to inclement weather, Lee recognized that socializing was just as important and has now included regular get-togethers at the practice which have an educational component such as a Falls Awareness Evening.*

*Nursing care here is exemplified in Leone identifying a local patient need and addressing both the clinical and psychosocial needs of her particular patient group.*

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### 3. AUSTRALIANS SHOULD HAVE ACCESS TO PRIMARY HEALTH CARE SERVICES WHICH KEEP PEOPLE WELL AND MANAGE ILL-HEALTH BY BEING MORE FOCUSED ON PREVENTIVE CARE, INCLUDING SUPPORT OF HEALTHY LIFESTYLES;

General Practice Nurses (GPN) are well-versed in all levels of preventative care, and are currently engaged in the promotion of wellness, secondary prevention and tertiary prevention. Nurses routinely undertake health promotion, lifestyle risk factor counselling, screening, and run chronic disease clinics which encompass, early intervention, coaching, and care coordination.

*This work can help our patients to empower change towards a healthier lifestyle in a simpler way. The majority of them don't need too much confusion. We at Barton Lane have proved that practice nurses providing [lifestyle modification advice] can be very effective.*

*Marion Goodman,  
Tamworth*

Nurses are ideally placed to be the key providers of lifestyle modification advice and supporting consumers in behavioural change. It is a core skill for registered nurses through their undergraduate training to be able to communicate effectively, support patients with behavioural changes and take a comprehensive approach to strategies which incorporate the patient's own experience, personality, and social networks.

GPNs are key providers of childhood and adult immunisation services in many countries including Australia. In most states there are legislative arrangements in place to support an autonomous role for nurses in immunisation that includes the administration of adrenaline. Unfortunately existing funding mechanisms prohibit the best use of these skills and thereby limit accessibility.

A good example of secondary prevention is cervical screening and the latest data from the Victorian Cervical Cytology Registry indicate that Pap tests taken by nurses in the state have doubled to 18,651 over the last ten years.<sup>2</sup> Research also noted that 79.9% of Pap tests conducted by nurses contain an important endocervical component, compared to 76.4% of tests conducted by other practitioner types.<sup>3</sup> The quality and safety of this work undertaken by nurses is ensured through an existing mechanism where nurses have to be 're-credentialed' every three years before being able to conduct Pap tests, this maintains practice standards and ensures a high and consistent quality of service.<sup>4</sup>

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We can say unequivocally that practice nurses are already undertaking this work in many practices. Many of our members seek support from us in this role, and have relayed to us their successes and the difficulties they face. Some practices, for example, have introduced patient co-payment to make this nursing care financially viable, whilst others include a GP attendance component to enable an attendance item number to be claimed. For these nurses, they find this enhanced role both rewarding for them professionally and of huge benefit to their patients. GPs are also benefitting from nurses working collaboratively in this way, as they [GP's] can easily refer patients to a health provider who can provide the necessary information, coaching and advice when a risk factor is identified.

In the area of lifestyle risk modification, time with the person concerned is critical and nurses generally establish more contact time with patients.

- Research indicates that the quality of consultations is relational to the amount of time spent between physician and patient.<sup>5</sup>
- Nurses spend more time with patients than doctors.
- Extended contact time facilitates nurses' ability to compile detailed, accurate patient medical histories, to undertake comprehensive assessment of the patients, and to assess the patient's family's medical risks.<sup>6</sup>
- The patient-nurse interactions act to enhance the therapeutic relationship, which create more opportunities to promote lifestyle changes.

There are however issues in the Australian context currently and are as follows:

- Funding mechanisms do not allow practices the flexibility to provide this nursing service in a way which reflects the nurses ability to operate autonomously and effectively. We will address funding mechanisms in another section in detail as the issues apply to range of nursing services.
- There is a need for a comprehensive and in one spot education program for lifestyle risk factor modification. Currently nurses access appropriate education from a range of different providers which has been generally developed for a different audience. We would like to see prevention and risk factor management to be recognised as a core skill for general practice nurses and included in any educational pathway for this specialty.
- Infrastructure in the practice poses issues in many practices. Risk factor counselling needs to be done in a private area and many practice nurses do not have access to a consulting room. We will also address this in more detail later.

Unfortunately, research evidence has not kept pace with the evolution of nursing practice in this area. Consequently we are unable to quote research on the specific contribution of nurses to lifestyle risk factor counselling, and secondary or tertiary prevention. Based on our expertise on this matter and the lack of research in this area, we would suggest the work of nurses in general practice in prevention is hidden and not fully acknowledged. A glimpse of the contribution nurses make is provided by an evaluation of a research project of GPNs providing smoking cessation counselling conducted in the Southern Highlands of New South Wales.<sup>7</sup> It was found that nurses spend more time counselling patients, increasing their chances of quitting and practice nurses were also 'uniquely positioned' and ideal for the role, as compared to General Practitioners (GP). It has also been reported that in co-ordinated care trials nurses are a major contributing factor in how clinical co-ordination of patients with chronic and complex needs was implemented, yet their role was largely ignored<sup>8</sup>.

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We recommend

- Flexible funding models to allow nurses to provide this service e.g. block grants or fee for service for the nurse time without needing to have the GP attendance during the clinical service. Both need to be modelled on providing patients with access to a long consultation and/or group sessions.
- Development of a competency framework and educational program for nurses wishing to enhance their skills in this area
- Recognition in funding models that nurses need appropriate space for such clinical activities and capital funding needs to be built into funding models

## 4. AUSTRALIANS SHOULD HAVE ACCESS TO PRIMARY HEALTH CARE SERVICES WHICH KEEP PEOPLE WELL AND MANAGE ILL-HEALTH BY BEING WELL-INTEGRATED, COORDINATED, AND PROVIDING CONTINUITY OF CARE, PARTICULARLY FOR THOSE WITH MULTIPLE, ONGOING, AND COMPLEX CONDITIONS

Practice nurses are critical in ensuring general practice delivers well-integrated and coordinated care in a way that promotes continuity of care. A growing role for nurses in primary health care, which makes full use of their existing nursing skills, is that of working with patients with multiple, ongoing and complex conditions. Everyday practice nurses see patients who are in great need of support in navigating our complex health and social services system. Nurses use the nursing process to assess, plan, implement and assess their nursing care. In the context of primary health care, nurses use this cyclic process to guide their flexible and patient-centred approach to assess patients or their family carers/family health and wellbeing, identify goals to improve their wellbeing, plan an appropriate course of action, for example to establish the services they need, establish an appropriate care plan, and identify which additional health professionals might be valuable. This is part of the intellectual work of nursing, occurs very quickly and always includes a consideration of the interplay between co-morbid conditions. This is a role which fully uses the wholistic approach of the professional nurse in clinical and service coordination and we would support a clearly autonomous role for nurses in this capacity within the general practice team.

In addition we advise caution in the consideration of the separation of clinical and service coordination in the general practice setting, as we are also strongly supportive of the concept of a wholistic approach to patient care. Non-clinical service coordination models which sit outside the practice do not seem to take advantage of the health professionals within the practice working together to provide a coherent service and plan of care for the patient. Such a model would increase fragmentation within the system and risk patient continuity and therefore the quality and safety of the service provided. We are conscious that existing funding models, can at times, redirect the clinical work of nurses away from this important area. This is why we recommend that this vital role be acknowledged and consideration be given to the context where this work is undertaken in relation to the pressure a business model places on the work undertaken by practice nurses. In the current system it is difficult for practices to get remuneration for his/her work in this area of coordination. APNA would recommend funding mechanisms be applied to the general practice setting to facilitate existing, unfunded work that nurses do, or alternatively make more efficient use of the available workforce by facilitating nurses ability to undertake this work. The perceived lack of time/workforce that is driving trials of other models or workers in the sector to undertake this work is based on a limited understanding of the role nurses play in this area.

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Having patients enrol with a practice would likely see the practices increase the role of nurses to provide services. Essentially, a capitated payment for services to a specific group of patients would allow the practice flexibility to use the best professional for the role, which is something we strongly support. However we would want to see this concept in more detail to ensure that no patients are disadvantaged and would suggest consideration of performance payment structures be put in place to encourage practices to ensure the most efficient, effective service is provided.

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*Care Coordination is excellent opportunity for an RN with specialist knowledge in chronic diseases & community resources & motivational interviewing techniques to help patients reach their goals to improve health outcomes. In the long term, in the overall sense, it is also a cost effective way in patient management, however it is not necessarily seen so to the practice as the care coordinator spends time in patient education and helping them in their goal setting. There is also the cost associated with not just the hourly rate of employment, but space/room in the practice, computer, etc.*

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*APNA member, Outer Urban Queensland*

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## 5. SERVICE DELIVERY ARRANGEMENTS SHOULD SUPPORT SAFE, HIGH QUALITY CARE WHICH IS CONTINUALLY IMPROVING THROUGH RELEVANT RESEARCH AND INNOVATION;

APNA are strongly supportive of any performance framework for primary health care but acknowledge we do not have expertise in this area.

We can say however that our colleague's experiences in the United Kingdom with the Quality Outcomes framework has been a largely positive experience and nursing roles have expanded under the utilisation of that framework to direct funds appropriately. Given that nurses are accountable for the care they provide, they are comfortable with being held accountable for patient health outcomes and quality of care and many of our members have expressed to us that they feel confident that they could deliver the required results. However pay rates for UK practice nurses have not automatically increased to acceptable levels as a result despite GP income increasing substantially. Any pay for performance framework would still need to have some protections for the health professionals delivering it who are not the business owners. This would ensure that the health professional who is held accountable for the quality and outcomes is also acknowledged if funding is increased as a result.

Development of a performance framework should be undertaken by a group comprising a range of relevant stakeholders including nursing representation to ensure that performance measures are achievable as well as evidence based. It has been our experience as the implementers of a number of macro level (system wide) policy initiatives, that the implementation of new strategies will be improved if they have input from the health care professionals who deliver the care at the micro (patient interaction) level of the system.

Research continues to be a significant issue for practice nursing. There is a growing body of research pertaining to GPNs in Australia. However, it has been driven largely by individual researchers' agenda, and is often around a condition area rather than as part of a coherent research strategy into the possible roles, issues and contributions of practice nurses to improve primary health care. We would advocate for an overall strategic approach to research into this specialty of nursing as the role is evolving rapidly and policy decisions are frequently being made based on little evidence of the Australian context. Further research into general practice nursing roles and their role how they improve outcomes for patients in general practice settings will add to the experiential evidence of the value of GPN work

To date, there has been little involvement of practice nurses in the development of research proposals thus far. This is in part due to the nature of the workforce – an ageing demographic, with many having undertaken their original training in a hospital setting. Research skills' training for practice nurses is needed to ensure they can contribute to the development of research as well as undertaking their own. We acknowledge this is gradually changing, as a consequence of past investment in the education of practice nurses by the Australian Government, consequently. We strongly recommend continuation of the post-graduate nursing scholarships to build research capacity within this sector of nursing. Also, consideration should be given to wider issues regarding how this growing workforce will access research funding into the future, whether that be through the National Health and Medical Research Council or the Australian Research Commission.

## 6. SERVICE DELIVERY ARRANGEMENTS SHOULD SUPPORT BETTER MANAGEMENT OF HEALTH INFORMATION, UNDERPINNED BY EFFICIENT AND EFFECTIVE USE OF EHEALTH;

For general practice nurses who play a key role in initial assessment, chronic disease management and coordination of patient care, access to an electronic health record is essential. For patients to have access and ownership of that record is very congruent with the partnership approach to care in nursing and we strongly support such an enabling resource for patients.

A more pragmatic but pressing issue for practice nurses is how their inability to access a computer and medical records impacts on their ability to deliver optimal nursing care. Workplace practices which mean that nurses are unable to access a computer and therefore the patient record places nurses in a position where nurses are unable to document the nursing care provided and increases the risk to patient safety because the care provided is not documented. These situations fall well below best practice nursing care, and inhibit nurses ability to access the latest guidelines, and patient resources. Nurses are legally accountable for the care they provide and access to record keeping in the same way as other health professionals in the practice is an essential micro level process of the legislative instruments that govern nursing care, and act to protect the public from harm. APNA recommend that access to patient records for nurses should be a mandatory requirement for practices to be accredited and or receive IT PIP payments.

**7. SERVICE DELIVERY ARRANGEMENTS SHOULD SUPPORT FLEXIBILITY TO BEST RESPOND TO LOCAL COMMUNITY NEEDS AND CIRCUMSTANCES THROUGH SUSTAINABLE AND EFFICIENT OPERATIONAL MODELS.**

We support the development of regional health organisations providing the governance of such organisations includes nurses. If these organisations are membership organisation, they need to include nurses as full members with voting rights and opportunities to play an active role in the governance. In this way the thoughtful contributions of the nursing profession will benefit the organisations. And the organisations will be accountable to nurses in the services they offer.

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## 8. SUPPORTING THE PRIMARY HEALTH CARE WORKFORCE ARE WORKING ENVIRONMENTS AND CONDITIONS WHICH ATTRACT, SUPPORT AND RETAIN WORKFORCE;

### a. *What changes in working arrangements and conditions will better support primary health care professionals?*

General practice nurses frequently work in very difficult circumstances. As compared to their hospital counterparts, the often 'cottage industry' nature of general practice has resulted in lower hourly pay rates, less support from their employers for professional development and isolation from other nurses. According to the APNA Salary and Conditions Survey 2008<sup>9</sup>, there is no correlation between location and salary rates, qualifications and salary rates, role and salary rates. It is generally up to the nurse to negotiate his/her terms and conditions which nurses find extremely challenging as they are not required to do it in most other settings. Frequently nurses have no contracts or agreements in place and it is not until the working environment goes sour that the lack of the contract becomes a real issue. The APNA is not an industrial organisation and hence cannot act for members in these situations but we received calls from and counselled over a dozen members in 2008 T summarily dismissed without entitlements. Add to that the many more who call with queries about inappropriate requests to work outside their scope of practice, inappropriate

*Everyone is aware that our rates of pay are what stop a lot of nurses making the transition, and when promoting general practice to nurses it seems only the students that appear interested others seem to glaze over when I get on my band wagon.  
APNA member, Rural Victoria*

governance structures within a practice management, and general poor treatment and lack of respect. There is a clear need to consider the employment conditions of this workforce when planning the future of the Australian Primary Health Care sector.

### b. *How is teamwork facilitated in primary health care services and between them?*

The role of nurses in facilitating team cohesion through such processes as communication, liaison, and continual quality improvement is another poorly acknowledged aspect of their role. Nurses are team players and this is now being recognised by research which demonstrates in the general practice setting nurses often act like the 'glue' for the clinical team.<sup>10</sup>

Clear clinical governance processes and procedures within a general practice needs to be clarified to determine accountability structures. Nurses must have their work funded directly rather than 'for and on behalf of' the GP. The 'for and on behalf of' statement in the MBS nurse item numbers perpetuates the

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myth that the GP carries all responsibility for clinical care provided by the nurse. Stipulations around the GP 'supervising' the nurse also creates a false impression that a nurse could defend a negligent act by claiming that the GP was responsible, had taught her, or she was operating under the GPs direction.

To add to the confusion, the medical indemnity insurers also provide conflicting advice to GPs and practice managers as their interest is vested in the GPs and the practices legal liability rather than the nurses. They also do not refer to nursing regulatory requirements when advising practices e.g. advising a practice that they are happy to insure a practice employing an enrolled nurse without any registered nurse supervision even though the law in that state is completely clear on the requirement for RN supervision.

The third complicating factor in general practice is that the GP is frequently the employer and there is significant confusion again between their obligations and responsibilities as employers versus as a health professional working within the practice team. Employers within general practice retain legal liability for all staff employed in their practice which differs from individual GPs retaining legal liability for activities delegated to the nurses. The only exception to this currently is when a solo GP employs the nurse directly in which case rather than through a practice entity/trust.

Registered nurses and enrolled/Division 2 nurses are accountable for their own activities and are responsible for ensuring that they practice safely within the bounds of their scope of practice. We strongly recommend that any strategy outline the need for clear clinical governance of any health service which respects the different health professionals which are employed within them.

## *c. How could the general practice nurse role be developed and enhanced?*

Enhancement and development of the practice nurse role should be prioritised in any primary health care strategy. It must be done in a way that recognises that nursing is more than a set of tasks and it must not be framed purely in terms of task substitution of work GPs are too busy to do. There are certainly areas of overlap between nursing and medicine, particularly in the focus in the general practice specialty on continuity of care, holistic all of life care and health promotion. It is these strong areas of overlap that can create some of the dissension in role enhancement for nurses as it can be perceived as trying to be a doctor and doing 'doctors' work.

Studies have shown that general practice nurses (GPN) are as effective<sup>11</sup> as General Practitioners (GP) in performing many primary care functions whilst receiving better results in patient satisfaction surveys.

- Nurse-led care may involve higher levels of patient satisfaction and quality of life than doctor-led care.<sup>12</sup>
- Nurses are better managers of interpersonal relationships<sup>13</sup>, through clearer communication, conducting effective counselling and possessing better interviewing skills

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- GPNs can provide long-term care management and promote choice and positive health.<sup>14</sup>

There are a number of strong reasons for focussing on developing and enhancing the role of practice nurses including

- Extending nurses' roles can relieve the GP workforce shortage.
- Nurses working alongside doctors can maintain (or increase) the quality of care.
- It must be noted that evidence from other countries has not demonstrated any cost savings in supplementing doctors with nurses. However, practice nurses were found to be as proficient as GPs, and hence, such a practice has demonstrated no adverse outcomes.<sup>15</sup> Practices should be able to take a flexible approach in staffing to meet the needs of their population knowing that this is safe and effective.

Practice nurses have the potential for a diverse range of roles in first-point contact care, many of which are only just starting to be explored, for example,

- Triage,
- Minor injury management,
- Neonatal, paediatric, and geriatric care,
- Occupational health care management,
- Chronic disease management (CDM)<sup>16</sup>
- Extended care functions, including providing links to support agencies.<sup>17</sup>

*I have just completed my child and family postgraduate certificate which I received a scholarship thru APNA to be able to achieve this... for which I am very grateful .I was quite amazed when they were discussing career options for future child and family health nurses the university omitted practice nursing. There was three students in that intake that were working in private practice so we made our voices heard*

## Challenges:

### 1. Training

Education presently does not adequately prepare nurses for primary care, having no comprehensive programme to train nurses for primary and community care.

### 2. Promotion of any defined career pathways are also lacking.<sup>18</sup>

There is a need to develop a coordinated approach to implementing a career framework for primary and community nurses.<sup>19</sup> This needs to align with existing career structures already developed for nurses in other settings and needs to be driven by nurses in the specialty, rather than other health professional groups or other organisations, thus ensuring it is nursing appropriate and addresses the particular concerns of those in the specialty.

### 3. Employment costs

The current Australian health system is not designed to make full employment of nurses a financially viable business decision for general practices

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## 4. Infrastructure

The existing funding systems are not designed to adequately provide for the proper working and training space of GPNs and offer little support in the training of new GPNs.

Nurses need consulting space within the practice to act at their full potential e.g. chronic disease management clinics<sup>20</sup>. Funding for practice nurses only covers their direct employment costs

## 5. Lack of information on what nurses in general practice currently do

Currently data collection methods are flawed and underestimate nurses' contributions. There is a need to develop systematic approaches to the collection of data on numbers and Equivalent Full-Time (EFT) hours of GPNs, care provided by GPNs and outcomes. A regular study similar to the BEACH study for general practice consultations would assist in determining what nurses are doing to whom and for what.

## 6. Expanding scope of practice safely

The regulatory framework within which nurses work is quite explicit about the decision-making framework for expanding scope of practice but often it is a challenge to enact it in general practice. . In order to expand his or her scope of practice, a nurse must be supervised by another nurse yet. Often nurses are being 'supervised' by their employing GP. Medical officers will not have a detailed understanding of nursing education and what are the appropriate steps to take in expanding scope of practice safely. We receive regular calls from members who are asked to expand their scope of practice but not being supported with access to appropriate professional development and supervision. Scope of practice for nurses is that which he/she is authorised, competent and confident to perform as determined by the individual nurse.

If nurses can access professional development and access to appropriate supervision, expansion to the scope of practice can be safely negotiated in the isolated general practice setting. However current practice structures and business pressures largely mitigate against this.

Changing funding models are required to stimulate the development of the practice nursing role. <sup>21</sup> Current funding of nurses in general practice significantly limits their contribution to general practice as an accessible, affordable health service. The existing funding system for GPNs comprises

- A mix of support of GP item numbers, for example Health Assessments, GP Management Plans,
- Practice Incentive Programme (PIP) subsidy for employment of a GPN (up to \$40,000 a year for a practice with 5 Equivalent Full-Time (EFT) GPs),
- GPN specific item numbers for immunisation (\$10.80), wound management (\$10.80), pap smears (\$10.80), pap smears plus preventive health (\$21.70), antenatal care (\$38.65) and chronic disease management (\$10.80).
- Rebates for CDM items are limited to 5 payments per calendar year, insufficient to recover costs.

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The rebates for the GPN specific item numbers do not account for the

- Qualifications of the nurse, encouraging practices to employ the least qualified nurse.
- Time spent with patients, encouraging nurses to consult as quickly as possible, making it counterproductive for roles such as chronic disease management.

Furthermore, rebates between GPN and GP items differ greatly, worsening the GP workforce shortage by encouraging the employment of GPs in procedures GPNs are well-qualified to do.

Current Fee-for-Service (FFS) systems prevent proper reimbursement and provide little incentives for GPNs. They also demand high throughput in service delivery, reducing the quality of care.<sup>22</sup>

Maintaining a high quality of care is an intrinsic motivation for nurses.<sup>23</sup> However, the reduced quality of care resulting from 'productivity pressures'<sup>24</sup> of the FFS systems result in poorer job satisfaction and make nurses feel more dissatisfied than members of any other female profession.<sup>25</sup>

A study has revealed that the deployment of limited resources drives impairment of nurses' non-wage rewards, such as patient-care quality and workplace control and quality.<sup>26</sup> This affects the job satisfaction of nurses and affects retention. More importantly, it adversely influences the quality of the service that can be delivered, ultimately affecting patient outcomes.

Indemnity insurance needs to be clarified. In one study 51.6% of practice nurse participants cited legal issues as a barrier to developing their role in CVD management.<sup>27</sup>

*d. How can newer models of care or newer workforce roles (such as nurse practitioners and physician assistants) better support health professionals to meet demands created by a changing primary health care environment?*

Nurse Practitioners are extremely highly qualified nurses who are legislated to be able to prescribe and refer already. They are extremely safe and there is no evidence available to demonstrate that Nurse Practitioners would pose any risk to patient safety in any way. Hence, it is puzzling as to why providing nurse Practitioners with access to the PBS for prescribing and MBS for referral for pathology and radiology would be anything other than an extremely useful adjunct to general practice. We currently have around 8 practices nurses undertaking the nurse practitioner courses, almost all at the instigation of their GPs some of whom will not fall into the remote and rural areas recommended by the NHHRC. Primary health care is currently missing out on this valuable and high quality resource. Not only will patients benefit from the greater access to care, having such career options for nurses will make the specialty more attractive for younger nurses and keep the ones we have in for longer.

It is worth noting that the 8 nurses currently doing their nurse practitioner training intend to work in general practice alongside the GP as part of the general practice team. Working in isolation where there are no GPs is not being seen as desirable. We strongly support the RACGP focus on quality and safety and believe there are strong advantages in terms of safety when health professionals work in teams rather than in isolation where possible.

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## APNA PRACTICE NURSING WORKFORCE RECOMMENDATIONS:

- A clear intention to employ nurses in primary care as a key and valued part of reform strategy should be developed to increase patient access to high quality clinical care.
- This needs to be supported by increasing the profile and the status of the nursing role in primary health care as a career path of choice. Adopting such a goal shall foresee a stronger focus on primary health care in nursing undergraduate training, nursing graduate years, GPN career paths, remuneration, and developing an integrated approach to nursing.
- Develop and promote a career pathway for general practice nurses that has levels from a new graduate to a nurse practitioner. Pathway should define key competencies and responsibilities at different levels and be linked to remuneration levels which will attract nurses to this important role
- Develop training models for general practice nursing as a specialty in its own right with a formal Continuing Professional Development program being a key component of recognition for specialist general practice nurses.
- Provide a clear governance framework for teamwork within the practice which recognises and respects the contributions and responsibilities of the different health professionals within, including nurses as health professionals in their own right and not subservient to the medical profession.
- Provide funding mechanisms for nursing services which allow flexibility to maximise the generalist and varied skills of the nurse. Funding mechanisms should reward participation in CPD similarly to vocational registration of GPs. They should also take into account the qualifications of nurses such as enrolled nurse, registered nurse, nurse practitioner in order to encourage practices to employ the most appropriately skilled nurse rather than the cheapest

## 9. SUPPORTING THE PRIMARY HEALTH CARE WORKFORCE ARE HIGH QUALITY EDUCATION AND TRAINING ARRANGEMENTS FOR BOTH NEW AND EXISTING WORKFORCE.

Broadly, we support any strategies to encourage interprofessional learning and competency based education from undergraduate through to continuing professional development. We have been a strong supporter of professional development for practice nurses both in the development of learning and administration of the Commonwealth funded scholarships.

Challenges for practice nurses specifically have been the lack of a framework of key clinical skills and competencies to govern the development of appropriate professional development. Compared to the robust processes surrounding the RACGP CPD Triennium, practice nurse education had occurred in a vacuum of structure. There has been significant investment in practice nurse professional development by the Commonwealth through both APNA and the Divisions of General Practice Network, however it is supporting access to professional development rather than driving the quality or content of professional development. Frequently nurses are required to source their professional development from a range of disparate providers which cannot be aggregated to a meaningful qualification.

In addition there are significant gaps in education currently and it is often left to entrepreneurial providers to identify the gap then develop the education with minimal consultation with the specialty itself. Whilst often this education may be adequate, we have no quality assurance processes which ensure that it is suitable for practice nurses, is respectful of practice nurses and is of high quality.

Another challenge for practice nurses and access to education and training is the inconsistency in value placed on professional development between practices. Access to study leave, paid time off and course costs is very ad hoc<sup>28</sup> Any funding mechanisms or performance measures should include support for all employed health professionals to have access to appropriate professional development.

Finally, we need to see practice nurses supported to be preceptors for undergraduate and new graduate nursing students. Currently any nurses supporting these future practice nurses are not provided with much support or remuneration for their time and yet it is critical to ensure new nurses see primary health care as a career path of choice.

## 10. PRIMARY HEALTH CARE IS FISCALLY SUSTAINABLE, EFFICIENT AND COST EFFECTIVE.

We would welcome funding models that promote collaborative teamwork in primary health care and access for consumers across the whole spectrum of the community i.e. the financial incentives and drivers are the same for all contributing to health care. Whilst we acknowledge that our expertise is not in this area, we would encourage any models that incorporate nursing across the diversity of primary health care. An example would be primary health care services with general practice nurses, school nurses, maternal child health nurses, midwives and home visiting nurses. This would reduce duplication such as we are seeing with the Healthy Kids Checks, antenatal care, wound management etc.

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## APPENDIX 1

### STORIES FROM APNA MEMBERS

What doesn't work well is the current model of funding on several accounts:

1. That of private businesses employing RN's at greatly lesser rates than their hospital counterparts. This alone means that PN's in GP practices are older with fewer younger nurses coming into the profession because the rates of pay are so low.
2. Older nurses are often very experienced but younger nurses are needed to replace and replenish the older burnt out ones. And to a degree, the older nurse may not be able to handle the changes required to assert change on their behalf, whilst younger nurses are seen to be more eager to achieve new roles and remuneration.
3. Most nurses are casually employed and put off when work when workload is believed to be decreased as a result of on Dr's holidays. This more than often leads increased workloads and does lead to increased stress and risks in patient care and little time to catch up on unseen background roles which RN's undertake.
4. The costs of continuing education is generally left to the RN, who not only gets a lesser hourly rate, but is casually employed and therefore is doubly hit when maintaining their skills and knowledge, taking time off to attend conferences and competencies is therefore extremely costly (PN education is not pro rata to their hourly rate). The costs associated with maintaining a portfolio are huge when added to this are association dues and indemnity and annual licences to practice.
5. \$11.40 for RN's to immunise, wound care, educate or perform cervical smears is shameful. It is a slap in the face, a double whammy, as it goes into the principals' pockets and not into the nurses. PDSA's have proved that to immunise a child properly takes 22mins average, taking into account, parent education, informed consent, administration and documentation and don't forget documentation includes practice documentation and patient held record.

APNA Member, Urban Qld

My area is women's health. I do Paps, unplanned pregnancy counselling, contraceptive counselling, STI testing and counselling and lots of educational consults with clients for anything to do with sexual health. (Menopause and sexual problems too)

My wish list for the federal government:

- ability to refer women for C&D after a Pap with abnormal result
- ability to prescribe treatment for STIs after screening with abnormal result

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- ability to refer for TOP after counselling client
- ability to prescribe any of the contraceptive methods after counselling (pills, Depo, Mirena, Implanon, and emergency contraception)

APNA member, Remote WA

I am wanting to implement pre-conception care as after attending a midwifery conference realised the huge issue of obesity in pregnancy so plan on providing rural pre-conception care with information for women wanting to get pregnant. I have realised that so many women have such lack of knowledge in this area. There are women that did not know to take folic acid. I also hope to commence antenatal care with the GPs.

I have found that women in the clinic realise when you are a midwife that they share information about breastfeeding: their problem experiences etc and I am sure that in some cases it has prevented them from stopping breast feeding. Information is shared when they get their children immunised.

APNA member, Rural Victoria

Before working as a practice nurse I worked in continence care. In the community there is no funding through DVA or through Medicare for people to see a continence nurse advisor. Doctors and nurses are doing CASS and DVA applications with no experience of the aids they are ordering. As we all know incontinence is a contributor in many other problems. Ultimately the patient needs a full assessment, conservative management, and then an aids assessment and trial before an application is attended. I believe constipation and incontinence are very badly managed in the GP and community setting

APNA Member, rural NSW

From Medical Observer 27<sup>th</sup> February 2009



IDENTIFYING a “desperate need” to improve health services for women has driven practice nurse Rachel Sargeant to change the face of the general practice she works in.

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Arriving at the Cairns practice four years ago, Rachel, also a midwife, found a disparity between the patient demographics and the needs of the community visiting the Draper Street Family Medical Centre.

The practice was heavily reliant on the 50-plus patient group and had only six young mothers on its books, despite the rising number in the area.

“We have such a transient population here with many young families, often here without the support of their own family,” she said.

“I was interested in setting up some antenatal care because there was so little support.”

With the backing of the GPs in the practice, she initially set about creating a community within the practice where young mothers felt comfortable.

Both the ante- and postnatal clinics expanded rapidly and the practice now cares for about 50 young mothers at any one time.

Rachel and her colleague Helen Gamble have also introduced a lactation clinic, a walking group, an exercise class with prams and a physiotherapy class.

“We are such a busy practice. Women were waiting four weeks for Pap smears, and now we can see them within a week. The GPs are happy... we say it gives them chance to do ‘proper’ doctor’s stuff.”

Despite it not being a bulk-billing practice, work is always hectic for the two nurses and 3.5 full-time equivalent GPs.

The practice charges \$45 for antenatal appointments, \$55 for postnatal care and \$75 for a home visit.

“We work so much as a team. There is no hierarchy system here. Everyone respects each other’s areas of expertise... It’s really refreshing.”

Rachel Sargeant is an APNA member and was a an APNA Best Practice Award winner in Women’s Health for 2008