Seeing patients first: creating an opportunity for practice nurse care?

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ABSTRACT

INTRODUCTION: Practice nurses see patients in both a planned (i.e. scheduled appointment) and an unplanned (i.e. opportunistic) manner. This study aimed to investigate how often and why New Zealand practice nurses see patients prior to the general practitioner and whether they organise their care to support unplanned, opportunistic activity.

METHOD: National postal survey from a random sample of 500 general practices, requesting a response from one nurse per practice. Semi-structured telephone interviews with a purposeful sample of respondents.

FINDINGS: Responses came from 225 nurses (51% of practices confirmed to be eligible). Nearly all (92%) said their work role was the same as that of others in their practice. Only 13% of nurses routinely saw patients prior to the doctor, while 24% would choose to do so it they could, and 65% thought it important. Positive and negative aspects of seeing patients first are presented. Constraints included time, their role assisting practice workflow and perceptions of patient expectations. Few organised their work to create opportunities for lifestyle interventions.

CONCLUSION: The current working environment of practice nurses in New Zealand does not readily support them routinely seeing patients before the general practitioner. We suggest this is a lost opportunity for patient-centred preventive care.

KEYWORDS: Practice nursing roles; opportunistic interventions; work organisation; primary health care; chronic conditions

'I was seldom able to see an opportunity until it had ceased to be one.'

Mark Twain (1835–1910)

Introduction

Practice nurse (PN) work can be considered as planned and unplanned. Planned work includes chronic care management clinics and similar ways of organising care to include blocks of protected time to engage with patients in relatively systematic and prescribed programmes. Unplanned work includes responding to patient needs as they present, and proactively taking opportunities to engage patients on issues which they did not present. It is this latter, opportunistic work that interests us in this study.

Identifying and using opportunities effectively was the principle behind the Brief Opportunistic Interventions programme developed by author BD and others at The University of Auckland.[1]

During course feedback of this programme, most nurses stated that the best time to use these person-centred skills was by seeing the patient before the general practitioner (GP) (personal communication B Docherty, 2009). Putting aside the fact that 23% of children and 29% of adults see a PN per year without seeing a GP,[2] these nurses saw it as problematic that, when patients saw a GP prior to the PN, the GP often set the preventive care agenda prior to any opportunity for the PN to explore the patient's agenda. One logical extension of such opportunistic activity would be for PNs to arrange their work to ensure that they routinely see every patient, 'planning' to create an 'opportunity'. We therefore sought to investigate if and when practice nurses can and do see patients first.

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Methods

A national postal survey was used to collect quantitative and qualitative data. Semi-structured interviews were conducted by telephone with a purposeful sample of survey respondents. Ethics approval was given by The University of Auckland Human Participants Ethics Committee (Reference number 206/381). In New Zealand, university ethics committees can approve studies of health care professionals, while the Ministry of Health committees can approve studies with patients.

Participants

A contact list for general practices in New Zealand was constructed from data held by the Department of General Practice and Primary Health Care and the Immunisation Advisory Service, both at The University of Auckland. The list contained 1915 organisations presumed to be general medical practices, from which 500 were randomly selected using the rand() function in Excel, and sent one copy of the survey questionnaire. We requested one response from a practice nurse per practice. The sample size was chosen on the basis of available resources, anticipating a response rate of 60%, and was considered more than adequate for the simple descriptive statistics planned.

Data collection: questionnaire

The content of the questionnaire was developed initially based on feedback from nurse training courses run by author BD and from anecdotes and experience in primary care by author TK. Drafts were iteratively tested for content and face validity with a panel of 36 primary health care nurses.

The final questionnaire, which can be found in Appendix 1 in the web version of the paper, consisted of 20 closed questions and 11 open questions. The closed questions asked about practice nurse demographics, professional qualifications, and preferences and practices. The open questions gave practice nurses the opportunity to expand on their answers and give examples. The questionnaires were tagged with a temporary identification code to track non-responders. The questionnaires were sent in December 2006, and a follow-up request was sent to initial non-responders in January 2007.

WHAT GAP THIS FILLS

What we already know: In New Zealand in 2006/7, 41% of adults saw a practice nurse in the previous 12 months and 85% attended a general practice. For practice nurses, this is largely for clinical care and planned, structured care.

What this study adds: A minority of practice nurses routinely see patients before they see the doctor, or organise their work to routinely support unplanned, 'opportunistic' person-centred care.

Name and address lists were stored independently of the questionnaires. Respondents were assured that they would not be identified in any report.

Data collection: interviews

Respondents to the postal questionnaire were also asked to provide their name and contact details if they were interested to take part in a follow-up telephone interview. From this group we purposefully selected 20 practice nurses to cover a range of age, ethnicity, employment and geography. The guide questions for the interview were developed following a preliminary analysis of the survey responses, and can be found in Appendix 2 in the web version of the paper. Questions were intended primarily to confirm our interpretation of the quantitative data. Written consent was obtained prior to each interview. The interviews lasted from 20 to 35 minutes, were digitally recorded and transcribed. We offered interviewees the opportunity to view their transcript and to receive a copy of our report.

Data analysis

Quantitative data were entered and checked in Excel. Qualitative data from the questionnaires, together with the interviews, were entered into NVivo v7.0 for analysis. A general inductive approach was used for a thematic analysis[3] that was initially undertaken independently by authors TK, NS and BD, then confirmed and enriched by consensus.

Results

Questionnaires

Five hundred questionnaires were sent out. Fifty-six proved ineligible (24 wrong address, general

practice had ceased operating, or the organisation was not a general practice; and 32 practices had no practice nurses. There were 225 responses giving a response rate of 225/444 (51%). These 225 individual practice nurses represented 225 practices, with a total of 843 practice nurses and 802 GPs. Ninety-two percent said that their job was the same as that of the other nurses in the practice, or they were the only nurse in the practice. Descriptive statistics for respondents are in Table 1.

Training in lifestyle behaviour change had been undertaken by 143 practice nurses (64%). Of these, most indicated condition-specific training such as for smoking cessation (46), diabetes (44), asthma (19) or exercise, weight management and nutrition (29), while only 38 described generic courses such as Brief Opportunistic Interventions training.[2]

The great majority of the nurses saw the positives and negatives of seeing patients first in purely transactional, workflow terms. They could take very different attitudes to what appeared to be the same activities:

> Don't believe I'm the slushy to do the observations. I have my own workload. (#102)

> Chance to get to know patients better, catch up with recalls, bloods etc. sometimes patients tell PN things they won't tell GPs. Good interaction time. (#23)

Responses are summarised in Table 2, which reflects responses from all the free text questions in the questionnaire. As in the quotations above, some of the comments contradict each other, presumably reflecting a variety of PN attitudes and work situations.

When asked when it would be beneficial for PNs to see the patient first, 147 PNs replied, most giving several examples. The great majority of examples were activities relating to practice workflow—emergencies, patients arriving without an appointment or when the GP was fully booked or running behind time. Thirty PNs nominated activities that are shaped by a specific schedule of tasks—such as 'diabetes checks', 'wellness checks', 'antenatal visits', 'new patient visits'—that, nevertheless could poten-

Table 1. Describing the 225 practice nurses, one per practice

	Summary statistic
Practice nurses per practice, median (range)	3 (1–24)
GPs per practice, median (range)	3 (1–12)
Hours worked by practice nurses, median (inter-quartile range)	32 (24–38)
Age of practice nurses, median (inter-quartile range)	48 (43–53)
Years as practice nurse, median (inter-quartile range)	10 (4–15)
Years at current practice, median (inter-quartile range)	5 (2–10)
Ethnicity, n (%) (missing data, 10)	
European/other	195 (91)
Maori	14 (7)
Pacific	4 (2)
Asian	2 (1)
Practice nurse has own appointment list	84%
Practice nurse sees, prior to GP, patients with GP appointment	
Sees all patients	13%
Would choose to do this if they could	24%
Feels it is important to do this	65%
Feels confident to do this	79%

tially be used to discuss lifestyle changes in a patient-centred manner. Seven PNs specifically noted the opportunity to engage in discussions and advice around patient lifestyle changes. Several specifically noted an advantage of their female gender:

> Most women are comfortable talking to another woman about menstrual, sexual, menopause problems. Some patients feel like they don't want to waste doctor's time so talk to nurse. (#84)

Only two specifically noted their role dealing with mental health issues:

> Depressed, embarrassed elderly woman needing reassurance. (#332)

Interviews

One hundred and thirty-two nurses indicated that they were willing to be interviewed, from which we selected 26. Of these, seven routinely saw all patients first and nine would choose to see all patients first if they could. Summary descriptions of the nurses interviewed are in Table 3.

Perceptions of 'usefulness' were the principal drivers of whether practice nurses routinely saw patients prior to the GP.

> I can't really see... practice nurses doing the consultations first before seeing [the doctor]. All I can do sometimes is... just take the occupation, height and weight, when they're doing some... CVD assessment. But most of the time, there's not much to do with them. (#452)

Usefulness was primarily seen as an administrative role that would contribute to the workflow of the doctors...

> It saves the doctors time because we can do blood pressures weights and take temperatures, get a basic history before they see them, so they just need to quickly scan the notes and they're already there. (#45)

...and their workflow came secondary to the doctors'.

Table 2. The positives and negatives of seeing patients prior to the GP: summary of themes from free text in questionnaires

Positives

- Time efficient mostly stated as for GPs, practice and patients, occasionally for PNs
- Continuity of care with PN
- Reduction of GP workload and stress, all patients do not need to see GP
- Screening, opportunistic education
- Assists GP with essential history prior to GP consultation
- PNs gain experience and educational opportunities
- Increases PN confidence in clinical skills
- Strengthens PN–patient relationships
- Strengthens GP–PN relationship, GP recognises PN skills
- Better care and outcomes for patients
- Autonomy to triage and initiate first aid for emergency patients
- Opportunity to use learned skills, e.g. brief interventions
- Strengthens nursing holistic approach
- More input from PN allows patients to utilise PN more
- Patients more likely to talk to PNs and to be more 'honest'
- Assist in diagnosis and treatment of acute cases
- Perception that PN is less busy than GP
- Improves access for patients when PN service free
- Establishes PN role with patients as independent health professional

Negatives

- Patient has right to choose provider (autonomy)
- Patient may want confidentiality or privacy
- Patients may expect to see GP not PN
- Total patient time in practice longer
- Relationship is with the GP not the PN
- Alters GP–patient relationship, PN undermining GP position
- New way of working for patients, patient resistance
- GP may not want patient to see the PN first
- Patients seen twice and history-taking repeated
- Time constraints, time waster
- PN workload increased, PN already too busy
- No financial reward for PN
- Not cost-effective for practice or patient
- Would reduce consultation time with PN and/or GP
- Increase work hours and paperwork for both PNs and GPs
- Not interesting enough, boring
- PN training inadequate
  - Misdiagnosis could occur
  - Lack of confidence
  - PN unable to assist in such areas as depression, complicated chronic management that requires GP input, counselling
  - In some cases only GP is the suitable provider
- Lack of suitable workplace space
- Difficult if PNs working as receptionist
- If only for follow-up...why bother?

PN = practice nurse
GP = general practitioner

> A lot of wounds have to be seen by the GP only for claiming purposes and it's a waste of time because you need to have the patient sitting around, you're waiting for the GP to come in... (#457)

The nurses might be 'useful' to patients by being time efficient with administrative issues.

> ...You'll be doing some treatment type care for them and at the same time you'll take note of their other health issues like recalls and things like that that they might be due for... (#490)

Nevertheless, there was considerable variation between nurses in what they saw as useful. Many saw themselves as never having anything useful to contribute by seeing patients first, while others each nominated a small number of specific medically-defined conditions—such as diabetes, asthma and sexual health—in which they felt sufficiently skilled and confident to see patients first. However, the skill list nominated by each nurse seemed very partial, implying that the medical conditions of the majority of patients could not be 'matched' by any one nurse.

The nurses who preferred to see all patients first, however, saw their skills in more generic terms that were independent of specific medical conditions. These nurses—a minority in both the questionnaires and interviews—spoke of their role forming and maintaining relationships with patients, and of sensing or seeking opportunities while performing administrative tasks.

> That's an advantage of seeing the patients in the first place, by doing the weight and by doing the blood pressure and finding out if they're smokers those are all the things that we do... we use every moment we can to educate. (#45)

Most nurses gave a sense of being pressured and controlled by time. Nevertheless, the few nurses who routinely saw patients first gave a sense of multi-tasking and using time, suggesting that time was the very thing they could offer the patient that the doctor could not.

> We're able to discuss those issues because we've got more time than the doctors have. (#45)

Frustrations with time pressure seemed more directed at patients and receptionists than doctors or the wider health system, and appeared to be accepted as inevitable.

Nurse perceptions and presumptions about patient expectations also formed a powerful influence on whether they saw patients first (or at all). Nurses mostly took it for granted that patients often came specifically to see the doctor—and, by implication, not the nurse:

> I also don't know how patients would react to seeing a nurse first if they've chosen to make a doctor's appointment. (#397)

...that patients had every right to do so:

> I feel that we're taking away patients' rights to a certain extent if we chose to do that role automatically. (#490)

...that patients were entitled to privacy and confidentiality that might extend to the doctor but not the nurse:

> ...They want to wait until the doctor if they feel it's something they don't want to discuss, if they don't want me to know they can leave it until they do see him. (#54)

...and that nurses, doctors and patients probably share an implicit sense of when it was 'useful' for the nurse to see the patient first. However, this may simply be a matter of patients, and nurses, becoming familiar with a new arrangement.

Table 3. Demographics of practice nurses (PNs) interviewed, n=26

Age	Median 46, range 32–62
Ethnicity	1 Asian 18 European 6 Maori 1 Pacific
Number of PNs in practice	Median 3, range 1–12
Type of practice	1 Accident and Medical 8 Rural 17 Urban
Years as PN	Median 7, range 2–31
Training in lifestyle behaviour change	17

> I have only one patient who has not wanted to see the nurse, out of all the thousands that we see there's probably one guy who would rather just see the doctor. (#45)

Discussion

Nurses undertook work they considered 'useful', that they considered to be acceptable to patients, and within limits imposed by time pressure. As such, only 13% of practice nurses routinely saw all patients before they saw a GP, while 24% thought it desirable and 65% thought it important. PNs viewed seeing patients first largely as an administrative role to assist practice and GP workflow. A minority took a different view, seeing patients first because they saw themselves as offering skills and a relationship that doctors did not offer. While most nurses acknowledged that they could become involved in opportunistic discussions while engaged in clinical care, there was no sense of routinely or proactively creating such opportunities.

A strength of this study is that we surveyed the entire country. The fact that 92% of respondents said their job is the same as that of the other nurses in the practice supports our strategy of sampling one nurse per practice, as it suggests that the respondents may be similar to the nurses not sampled in the same practice. Nevertheless, our response rate of just over half calls for caution interpreting the results. We have no data to describe the practices from which we received no response.

The nearest comparative data to our survey is from a recent evaluation of nursing developments in primary health, which included a national survey of PNs.[4] The response rate to their survey was only 34% and included 384 practice nurses. This evaluation made it clear that PNs around the country are increasingly taking up the (planned) activities involved in structure projects,[5] as was hoped and expected following *The New Zealand Health Strategy*[6] and *The Primary Health Care Strategy*.[7] The increase in structured care by PNs is reflected in the current study, but it also seems clear from our work that the dedicated time devoted to structured care, reflected in the number of nurses with their own appointment list, is one of the barriers to PNs taking up unplanned, opportunistic activities.

Given the perennial problem of patients spending 'too long' in waiting rooms, we suggest that PNs routinely seeing patients first is an opportunity that is largely missed. Seeing patients first also represents an opportunity to profile PNs, especially given findings that PNs are frequently anonymous and 'invisible' to patients, and that patients can enormously value a personal professional relationship with a PN.[8] In profiling PNs, seeing patients first would help break down one of the very barriers mentioned by our respondents, when they considered that some patients expect and prefer to see the doctor.

A seminal paper that shaped the theory of general medical practice proposed 'opportunistic health promotion' as one of four key dimensions of the 'exceptional potential' of the GP consultation.[9] We suggest that the same opportunity can be taken or created within PN care, recognising that this needs appropriate training and working conditions that formally acknowledge and support this role.

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COMPETING INTERESTS
None declared.

Appendix 1: Questionnaire (Practice nurses seeing patients first)

Please circle Yes or No where asked

About your practice	
How many PNs in your practice?	
How many GPs in your practice?	
About how your work is organised	
How many hours do you work each week?	
Do you have your own appointment list?	Yes/No
Do you see all patients prior to the GP when they have an appointment with the GP?	Yes/No
Do you see all patients prior to the GP when they do *not* have an appointment with the GP?	Yes/No
Do the other PNs in your practice do the same as you?	Yes/No
If not, please explain.	
Your attitudes towards seeing patients first	
Do you believe that seeing patients first is an important part of PN work?	Yes/No
Please explain.	
Would you choose to see all patients first if you could? If not why not?	Yes/No
Do you feel confident to see all the patients first?	Yes/No
Please explain.	
If you were to see all patients first what do you see as:	
the positives.	
the negatives.	
Have you ever worked in a practice where you triaged or saw all patients prior to the GP? If so, did the patients accept? Please comment.	Yes/No
Have you ever surveyed your patients to determine whether they would have any objections to this structure? If yes, what were the results?	Yes/No
Please give examples of when it would be beneficial for practice nurses to see the patient first.	
Would you be more inclined to see all patients first if it was a directive rather than choosing to do so?	Yes/No
When you see patients first, do you have a routine you expect to follow, regardless of what the patient initially came for? If so, please explain.	Yes/No
About you	
How old are you?	
What is your ethnicity?	
Which professional bodies do you belong to? (e.g. NZNO, College of Nurses Aotearoa NZ)	
Have you had any training in interventions for lifestyle behaviour change? If so, please name or describe the training.	Yes/No
How many years have you been a practice nurse?	
How many years have you worked in your current practice?	
Is there anything you would like to add?	

Appendix 2: Interview guide (Practice nurses seeing patients first)

1. Thank you for agreeing to an interview. I know you have read the Participant Information sheet and signed a consent form, but I would like to remind you that I am recording this conversation, and that you can ask me to stop recording at any time, and that you can ask me to withdraw your information from the study. Are you still happy to go ahead? Do you have any questions at this time?

2. I have your questionnaire in front of me, and you wrote a comment that reads …… Would you mind explaining what you meant by that comment?

3. We have done a preliminary analysis on the questionnaires, and most nurses, including you, say …… That surprised us a bit, can you explain why you and others might say this?

4. Our analysis of the questionnaires also showed that most nurses say …… In this case you said something different, ……can you explain this please?

5. Is there anything further you would like to add?

6. Thank you very much. Just to remind you, we will transcribe this recording, and can send you a copy, or I can send you a copy that you can play on your computer.
   Goodbye and thanks again.