

Nurses' perceptions of nurse-led healthy lifestyle clinics

Bob Marshall PhD, Sue Floyd MN, Rachel Forrest PhD

Faculty of Health Sciences,
Eastern Institute of
Technology, Napier,
New Zealand

ABSTRACT

INTRODUCTION: Nineteen Nurse-Led Healthy Lifestyle Clinics (NLHLCs) were implemented and targeted Maori, Pacific and people living in high deprivation areas. The general focus of the clinics was on lifestyle issues and much of the nursing was educative and preventative care. The aim of this project was to assess nurses' experiences and opinions of their participation in the clinics.

METHODS: Nurses participating in the clinics were asked to complete a monthly narrative report over five reporting periods, and these were collated and evaluated for emergent themes. Sixteen nurses were subsequently interviewed and the transcripts analysed to identify major themes and sub-themes.

FINDINGS: In total, 167 narrative reports were collected from 53 of the 115 participating nurses. Almost all the nurses either strongly agreed or agreed that they enjoyed working in an NLHLC. This enjoyment was the result of: increased time for in-depth consultations, being able to provide enhanced holistic patient care, developing knowledge, gaining experience, receiving positive patient feedback and the satisfaction of seeing patient improvements. Nurses reported that the opportunity and responsibility of providing holistic nursing care, and the skills and knowledge gained from participating in the project, were extremely valuable.

CONCLUSION: NLHLCs provide benefits for both patient and nurse. For the nurse, job satisfaction is increased through positive patient feedback, opportunities for professional development and a greater feeling of empowerment.

KEYWORDS: Nurse-led clinic; self perception; lifestyle risk reduction; nursing evaluation research

Introduction

In February 2007, a New Zealand Primary Health Organisation (PHO) initiated the Nurse-Led Healthy Lifestyle Clinic (NLHLC) project in order to reduce inequalities among those populations that are known to have the worst health status, namely Maori, Pacific and people living in high deprivation areas¹ (quintile 5 addresses or NZ Deprivation Index 9–10 decile areas) by providing accessible, affordable and appropriate care.²

A 'nurse-led clinic' was defined as a holistic, patient-focused clinic run by registered nurses in primary health care settings, particularly general practice, Hauora and community providers. The NLHLC project involved 19 healthy lifestyle

clinics which were run across 17 providers (three Hauora, two community and 12 general practices) from throughout the region served by the PHO. Each provider structured clinics according to staff availability and expertise, resource availability, venue suitability and patient demand, which resulted in a wide variety of clinic frequencies and durations. All of the clinics were run on a part-time basis as one component of the nurses' responsibilities. In each clinic the nurses had their own patient caseload and the range of healthy lifestyle clinics included diabetes, smoking cessation, diet/nutrition, women's health, cardiovascular and asthma/respiratory clinics. Patients were referred or invited to the clinic by the nurses or the extended team in which they

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CORRESPONDENCE TO: Bob Marshall

Professor, Faculty of
Health and Sport Science,
Eastern Institute of
Technology, PB 1201,
Napier 4142, New Zealand
bmarshall@eit.ac.nz

were working. The NLHLCs were free to the PHO-enrolled population who met the inclusion criteria (Maori, Pacific and people living in high deprivation areas). The NLHLC project also prioritised continued nursing education in order to enhance nurses' ability to deliver health care in their clinics.

Research has shown nurse-led clinics (NLCs) are effective in enhancing self-management of disease,^{1,2} are an acceptable alternative to a general practitioner (GP) consultation,^{3,4} provide equivalent care for minor conditions compared to GPs,⁵ and are appreciated by patients for the extended time available for consults.⁶ While NLCs have shown significant improvements in patient outcomes and perceptions of health care both overseas and in New Zealand,⁷⁻¹⁰ there is limited information on nurses' experiences and opinions of their participation in NLCs. Phil-

lips and colleagues¹¹ note, while not referring specifically to NLCs, the many nurses in their study who "expressed frustration at the limited clinical care they were able to provide in general practice". They outline the many skills of experienced nurses which would support more independent practice.

Methods

Two methods were used for collecting data. The first was a content analysis of the narrative reports provided by the nurses, and the second was a thematic analysis of responses to the semi-structured interviews with 16 nurses.

The 115 nurses participating in the clinics were encouraged to complete monthly narrative reports, responding to nine questions (Table 1) about their practice and the clinic processes. Anonymous comments were collected over five reporting periods between 2007 and 2009, collated by question and a content analysis was undertaken by two researchers for emergent themes.

The number of narrative reports completed by a nurse was considered to be indicative of their involvement with the project. Although the narrative reports were anonymous, the number of reports completed by each nurse was available and used to select interview candidates. Within each group of providers, half of the interviewees were chosen because they had not submitted any monthly reports ('uncommitted' nurses), while the remainder were chosen for the relatively large number of reports they had completed ('committed' nurses).

Semi-structured interview questions (Table 2) were developed from the themes identified in the narrative reports. One of the authors (RF) interviewed 16 nurses (four from Maori providers; four from community providers; and eight from mainstream providers) and these were recorded, transcribed and analysed to determine their views of the NLHLC project and to expand upon the narrative reports. Transcripts were analysed independently by two researchers (BM, SF) for emergent themes and subsequently combined and refined. No attempt was made to determine differences between committed and uncommitted nurses.

Table 1. Narrative report questions

1	Do you enjoy working in a nurse-led healthy lifestyle clinic?
2	What is working well for you/what has made your job enjoyable this reporting period?
3	Is anything not working so well?
4	Please describe any barriers (for the enrolled population, for your or for your organisation).
5	Do you have any comments to make on the process or the outcomes of the self-audit you have undertaken of 10% of the people seen in your clinic this reporting period?
6	What nurse-led clinic education sessions would you like to attend in the future?
7	Please detail any continuous quality initiatives you have implemented this reporting period.
8	Can you identify any future opportunities for the nurse-led clinics project?
9	Do you have any other comments/suggestions/feedback for the primary health organisation?

Table 2. Semi-structured interview questions

1	Do you think the Nurse-Led Healthy Lifestyle Clinics have been effective in reducing hospital admissions? Why/how?
2	Do you feel you extended your skills and/or knowledge through participating in this clinic? What sorts of things did you learn? What situations allowed this?
3	What were the main benefits to your patients from these clinics?
4	Did this project have any effect on reducing barriers for some of your patients? What sorts of things helped? Did you initiate those or were they part of the project design? What else might help reduce barriers for your patients?
5	What were the barriers for you in the project? What did you do to minimise them?
6	Did you see patients on repeat visits under other funding schemes (such as Careplus)? How did that work?

The study received ethical approval from the institutional ethics committee and a New Zealand Ministry of Health Ethics Committee.

Findings

“... the main benefits to our patients were that they got health care that they wanted, in the way they wanted it, when they wanted it.” (Nurse 7)

Monthly narrative reports

A total of 167 narrative reports were received from 53 of the 115 participating nurses. The number of responses from each practice varied, with an average of 40% of the nurses completing reports. Approximately 74% of the nurses in the rural/community practices responded, while the response from Maori providers was around 5%, and slightly greater than 40% of nurses in general practices provided narrative reports. As noted below, many nurses found the monthly audits onerous and we hypothesise they felt the same way about the narrative reports. This, combined with workload, may be the factors contributing to the low response rate from some practices.

Overall, nurses were positive about NLCs and either strongly agreed (69%) or agreed (30%) with the question, “Do you enjoy working in a nurse-led healthy lifestyle clinic?”. When asked what worked well or what made the job enjoyable, several themes emerged: time for in-depth consultations, enhanced patient care, developing knowledge, positive patient feedback and patient improvements.

Nurses expressed a great deal of satisfaction in having the time in consults to take a more holistic approach to patient care than usual.

“Having allocated time available to spend with patients in clinic within busy practice setting allows for more holistic patient-centred care.”

Nurses consistently commented on the positive patient feedback they received, as well as the satisfaction of seeing improvements in patients' conditions and patients taking responsibility for their health. Finally, many nurses commented on how the clinic gave them the opportunity to de-

WHAT GAP THIS FILLS

What we already know: Research has shown nurse-led clinics can provide enhanced patient satisfaction with their care and continuity of care, that care for minor conditions is as safe and acceptable as from doctors, and that they are effective in enhancing self-management of disease.

What this study adds: Nurses' experiences and opinions of their participation in nurse-led clinics demonstrates that these clinics provide nurses with opportunities for professional development and a greater feeling of empowerment.

velop their own knowledge, or gain experience in applying information they had previously gained from in-service courses.

The themes which emerged from question three—“Is anything not working so well?”—included concerns and issues with the computer template being used, continuity of approach and funding, and dissatisfaction with the COOP questionnaire.

Many nurses found the computer template to be both limiting and directive and found the template difficult to apply to a number of areas, such as smoking cessation, cervical screening, asthma and women's health.

“The [template] is too prescriptive and restrictive. It is mainly around the care plan side. ... My women's health and respiratory patients do not fit into the care plan at all.”

Across all of the survey periods nurses expressed concern and frustration over the changes in eligibility and continuity of funding.

“I am turning people away as I can't fund enough.”

However, since there were no changes in funding or eligibility, these comments indicate a problem with the initial introduction of the nurses to the project and the description of the target population. Some nurses voiced frustration at having to choose which patients would receive a funded clinic visit over other, equally deserving, patients who were not part of the targeted population.

The COOP assessment was not popular with many nurses, and several reported how it was a low priority for them. Concerns, as exemplified by the comments below, included the length of time it could take to complete, as well as a lack of understanding or belief in its usefulness.

“I don’t use the COOP assessment. I don’t find it useful at all.”

“COOP assessments can, for some, take a long time. Leaves less time for careplans. I often avoid COOP assessments.”

Question four concerned perceived barriers and several new themes emerged, including patients not attending appointments and problems with the availability of clinic appointment times. The number of ‘did not attend’ patients was an issue for most practices. This was combined with frustration over the target populations being particularly difficult to contact and to encourage to book a clinic visit.

“Target population [is] hard to get to clinic, or they book and do not attend.”

Limited availability of clinic times (presumably as a result of staffing or space issues) was an issue for most practices. Many noted the clinic times precluded many patients who were eligible for, and in need of, support. One practice implemented a Saturday clinic in an attempt to become

available to a wider group, while another took a flexible approach to clinic times.

“Clinic is on Wednesday mornings but most people we are targeting are working. Therefore [we are] fitting them into other time slots.”

The answers to question five revealed that the requirement to perform monthly audits of 10% of patients polarised the nurses, with some commenting that the monthly audits were too prescriptive and onerous, while others said the audits were useful as a self-check. These two viewpoints are noted below:

“It feels very big brother to me. Already the PHO has the ability to track what I do and don’t do in my clinic. I feel I am doing things like COOP assessments just to make the stats look good.”

“I do the self-audit on more than 10% of consults as it is helpful to reflect on how I’ve done things.”

However, most nurses commented on the satisfaction of receiving positive feedback from patients about the clinics.

“People appear to really appreciate the clinic. They seem pleased that they do not necessarily need to go straight on medication but can make big changes by addressing lifestyle issues.”

Nurses were also asked what other NLC education sessions they would like the PHO to provide in the future. Responses to this question were collated and are presented in Table 3.

When asked to detail any continuous quality initiatives implemented, the themes which emerged included the development of resources or information packs for patients and initiating and developing recall systems for patients.

“This month [I] went to [the] supermarket and did a list of good food and bad foods to give to patients.”

“Have made up Healthy Lifestyle packs with basic information about BP, cholesterol, healthy eating, etc.”

Question eight asked the nurses to identify any future opportunities for the nurse-led clinics

Table 3. Requests for nurse-led clinic education sessions

Education session	# requests
Healthy eating/weight management	25
Diabetes	21
Asthma	12
Women's health	9
Chronic obstructive pulmonary disease (COPD)	8
Smoking cessation	7
Cardiovascular risk/disease	6
Stress/mental health/motivation/interviewing techniques	5
Lab tests, cholesterol, sexual health, menopause, chronic diseases, social problems, palliative care, elder care, grief, men's health, cultural safety, sleep disorders, cancer, pharmacotherapeutics, exercise, wound assessment	<5

project. While a wide range of suggestions were made, the topics which were consistent across practices and time periods were sexual health, women's and adolescents' health, and respiratory disease/asthma/chronic obstructive pulmonary disease (COPD).

Finally, when asked for any other comments/suggestions/feedback, three general themes arose. The first was that the need for healthy lifestyle clinics in the community is far greater than current availability; the second was that the computer template could be improved substantially, and the third was that the nurses appreciated the opportunity to work in a clinic and appreciated the PHO's support.

"I feel these clinics are a great initiative but feel we are only touching the surface."

"Am really loving being part of the nurse-led clinic experience. Have had positive feedback from patients with significant weight loss and healthy living improvements noted and improved confidence."

Nurse interviews

Semi-structured questions were developed from the narrative responses and 16 nurses were interviewed. Four major themes emerged from the data, each with a number of sub-themes. The major themes were: improved health care; patient empowerment; nurse empowerment; and project concerns.

Improved health care

In general, nurses were passionate and positive about their clinics, and their ability to deliver enhanced health care formed a large part of this attitude. A variety of factors contributed to this improvement, including: reducing some of the barriers to patients accessing health care; time for in-depth consultations and building relationships; development of a holistic approach which was inclusive of family/whanau; development of resources or information packs for patients; and initiating and developing recall systems for patients.

Consistent comments from the nurses related how the clinics reduced barriers to health care for

their patients. One of the obvious influential factors was the removal of charges for attending the clinic, but a number of nurses also commented how removing that cost influenced other factors in a positive way, such as making travel expenses more bearable.

"... it's removed the cost barrier or it's enabled us to provide more for our patients without even incurring costs." (Nurse 2)

"Again, it's the cost of travel as well as having, not having to pay for a doctor's visit as well ... some of our patients actually live about 100km out from here." (Nurse 12)

A number of nurses suggested that making the clinic mobile (i.e. allowing the nurse to go to the patients rather than requiring the patient to come to them) would enable the provision of a better service. However, a few nurses commented that relationships and agreements with other agencies meant that patients with transportation issues could be picked up and brought into the clinic. This inter-agency collaboration allowed for enhanced health care delivery.

"So they'll [another service provider] pick up our patients if we can't reach them [and bring them into the clinic]." (Nurse 1)

The provision of up to an hour per consult was viewed as hugely valuable in developing a relationship with the patient and through that relationship allowing a wide variety of health issues to be discussed. Many nurses commented that the reason for the initial referral to the clinic often turned out to be less important than other issues which, as a result of the relationship which developed between the nurse and the patient, were also able to be addressed.

"I've still got some of the people from my first clinic... 2007 I think it started. She's coming back in January and she was originally referred to me for smoking cessation—we finally might actually tackle that. ... She had other priorities than what her doctor thought she should come to nurse-led clinic for, ... and we've, all in that time frame, we've gradually sorted through them and it's great." (Nurse 13)

Another aspect regarding holistic care was that, during discussions, a concern with another family member would arise and the nurse was able to suggest a course of action for that person. Thus the influence of the clinics became wider than just the immediate patients. As these nurses said:

“You can pick up on things. They can mention something about their son and you think, mmm that doesn't sound right, or maybe you should bring them in and we'll have a look.” (Nurse 3)

“If the younger ones can't get to the clinic the older ones are taking the message home and so it's definitely impacting on families.” (Nurse 12)

Several of the nurses interviewed (and not just those working with Maori providers) noted that the clinics allowed them to be more culturally sensitive to patients' needs. A large part of this was the time available for discussion, but the lack of formality and talking to someone they felt comfortable asking questions of, also played a role. For example, nurses commented:

“They feel more comfortable, and again, coming here feeling that their cultural needs won't be trampled on.” (Nurse 9)

“[It's] the time thing, you know, especially our Maori patients. They like it when they're not rushed ... and then they do have time to say 'look the doctor told me that and I don't get it'.” (Nurse 6)

Patients' lack of understanding of their health problems was a common theme. This inhibited care, as the patients often failed to see the connection between their health issue(s) and their actions. Many nurses commented that having the time to discuss and explain health issues frequently gave the patients a better understanding of the role of self-management of their health. The relationship that developed between the nurse and patient allowed the nurse to become a 'health resource' for the patient:

“I am their tool—so they ask me questions and I tell them exactly how and what is happening to them, and they sort of take charge [of their health care needs].” (Nurse 1)

“So there's a relationship [which] gives them a resource, you know an advocate, someone who can not only see them in a clinical situation but can follow them through their journey, you know their health, what do they call it, their health pathway.” (Nurse 10)

The development of resources or information packs appeared to be widespread, with some practices initiating contact with other people and groups who may be able to assist with patients. Several nurses described developing and collating information on various diseases which was then made available to patients, usually in printed form. A couple of nurses mentioned attending courses (such as a smoking cessation course) which they thought would be relevant to their clinic role.

One of the interview questions asked if they thought the clinics had reduced hospital admissions. The majority of nurses responded that, while they hadn't seen any hard data indicating that had happened, they believed that providing early and consistent care for health problems which had the potential to become more serious would have an effect of reducing hospital admissions in the future. For example:

“We've managed to support people... that would usually have hospital admissions at least once or twice a winter with either asthma or things ongoing from infection, and we've managed to keep them either out of hospital or have [just] one admission.” (Nurse 7)

In particular, nurses noted that attending to patients' cardiovascular risk factors, or issues such as insulin resistance, could significantly alleviate future problems. However, one of the issues in motivating patients was the need to make their health problem 'real' to them, since they are often not physically visible. Nurses noted that linking a discussion of the patient's health with immediate blood test results achieved with 'point-of-care' testing was extremely effective.

“I've found that if you can do point-of-care testing then people have a lot more relationship to the results than if they go off and have the test and get the results back [much later]. So if we can do it

right there and they can see their blood going whizzing round and coming out with this number, I've found that to be a much healthier process for both people because you're moving from talking about something, to finding out some information, to setting up a plan of how to deal with it." (Nurse 7)

Patient empowerment

Another theme which emerged related to patient empowerment. Nurses talked about patient health improvements, positive patient feedback, increased patient responsibility for healthy lifestyle changes, reduced health risk behaviour, and from a negative point of view, patients not attending the clinic. A consistent general theme throughout the interviews was the effect of the clinics on patients' attitudes. This arose from a variety of factors, including the development of a relationship with the nurse, the ability of the nurse to explain aspects of their health issue clearly, and an understanding of the aims and objectives of the care provided.

As with question two, nurses commented on the satisfaction of receiving positive feedback from patients about the clinics. This covered a range of aspects from patients' satisfaction with the clinic itself, to seeing improved responsibility for healthy lifestyle changes and reduced health risk behaviour.

"People appear to really appreciate the clinic. They seem pleased that they do not necessarily need to go straight on medication but can make big changes by addressing lifestyle issues." (Nurse 5)

The development of individuals' responsibility for their health was one of the attitude changes noted by many nurses. Patients would often be resistant or indifferent to proposed care until the condition, lifestyle factors and care were explained. Once they understood the relationship between these aspects, their attitude changed toward their health care.

"Now that we've changed our approach to patients they're more empowered, they're more on board, they're more ready to take responsibility for it and ready to accept treatment for it." (Nurse 2)

"... if you provide people with support then they'll go further and they'll not see things as barriers...,

[but] as just being things that need to be negotiated..." (Nurse 7)

Some of the nurses commented that many of the clinic's patients were from traditionally under-served groups, and that having developed a relationship with one person, they found word-of-mouth recommendations resulted in other members of the whanau/family attending the clinic. One aspect of this appears to be the development of trust/faith in the nurse and then the health care system (perhaps linked to reducing cultural issues), resulting in improved health care for those people. One nurse commented:

"When they [Maori] first come in, you know, [I say to them] I want to work together with you, for you to be able to control this, and they respond to that." (Nurse 1)

Nurse empowerment

A third theme related to how the nurses felt empowered by participating in the clinics. This related to extending their knowledge, gains in confidence, and from the positive feedback received from their patients. Nurses overwhelmingly indicated support for the project from a personal perspective. Through seminars and courses offered by the PHO, they extended their nursing skills and knowledge, including aspects relevant to providing a holistic approach to care. This gain in skills and knowledge, as well as elements related to successes in working with patients, resulted in an enhanced self-image for many nurses. Overall, nurses felt empowered as a result of participating in their NLHLC.

Many nurses commented on how the clinic gave them the opportunity to develop their own knowledge, or gain experience in applying information they had previously gained from in-service courses. An aspect of their knowledge development included gaining an understanding of the resources available to them in dealing with problems, as well as knowledge gained from developing written resources to make available to their patients.

Through courses and seminars provided or funded by the PHO, nurses were able to extend their skills and knowledge. As one nurse commented:

"I feel far better equipped for patients to understand just using one of the diagrams that she's given us ... and they can see immediately what they need to do, It's not just all about diet and exercise." (Nurse 2)

Given the time available in the consultations and the relationships which developed between nurses and their patients, health issues beyond the original referral were often raised. This broadening of the topics gave nurses the opportunity to provide more holistic health care which, in general, they found very satisfying.

"Like, you might have somebody for instance who is a diabetic, comes for a diabetic check but [their] main presenting issue for that person at that time is not their diabetes. And then you can put systems in place, get them linked into the appropriate people ... so we were able to wrap a whole lot of different things around her just from one clinic appointment which diabetes never even got addressed. It was least of her worries." (Nurse 2)

Another consequence of the length of time of the consults, plus the responsibility resulting from the range of nursing care provided to patients, was an enhanced self-image as a nurse. As the two nurses below comment:

"I feel quite empowered by it—I really quite enjoy it. [You] pick up on other sorts of stuff that [have] never been picked up before, because we've had the time. And then you also form this relationship with people and that's quite valuable really." (Nurse 3)

"I love doing this work... because I feel that it's a very honourable way of being a nurse and it's very honourable for patients to be treated in this way." (Nurse 8)

Project concerns

A variety of concerns were expressed. These related primarily to the limitations imposed by funding restrictions on the time available for the clinics, space to conduct them, and the uncertainty of continuation of the clinics. The computer template developed for the project received considerable comment, as did the inclusion/exclusion requirements.

While one of the major positive comments about funding was that the free clinics facilitated health care for under-served groups, the major concern was that the funding was insufficient for the existing need. Every nurse interviewed said they either had waiting lists for appointments, or that they simply couldn't accept all the people who were referred to the clinic. A number of nurses mentioned trying to move patients to another funding stream, where appropriate, after their initial clinic consultation.

The limited availability of clinic times and space in which to run clinics was a concern for most practices. Many noted the clinic times precluded many patients because of work commitments.

"We need to be offering clinics outside of working hours." (Nurse 2)

The computer template continued to generate comments in the interviews. For a number of nurses it was viewed as inappropriate for their clinics, given its [perceived] emphasis on cardiovascular risk. The quotation below illustrates this. However, while the computer template had an initial emphasis on cardiovascular risk, it always had other components, and it developed over time to cater for other clinic specialities such as asthma. This suggests the initial impression of the tool had such a negative effect that some nurses did not then follow its development and missed its later usefulness for their speciality.

"I don't think all that other stuff needs to be in it [the computer template]. There's lots of stuff, there's lots of assessment tools and all that and often, I mean you're just doing cardiovascular risk—that's all they [the PHO] want." (Nurse 16)

Some nurses contrasted their positive impressions of the overall project with a complete lack of support for the tool:

"We had this whole kind of living dynamic process that was possible through the funding project. The way it was set up it was very dynamic and I felt it was quite creative, and then the [computer template] was just so dead and so limited and it was so static." (Nurse 7)

Another area of concern for the nurses related to inclusion requirements for participation in the NLHLC project.

“Well there’s funding... for certain people and there are other people here that I deem just as needy, but unfortunately they don’t fit into that criteria.” (Nurse 6)

Discussion

The aim of this evaluation was to assess nurses’ experiences and opinions of their participation in the NLHLC’s project. There was a clear perception of the delivery of improved health care for patients in the clinics. The narrative reports and nurse interviews along with the patient satisfaction surveys¹³ all emphatically stated this.

The general focus of the clinics was on lifestyle issues and much of the nursing was educative and preventative care. The potential of the project to produce long-term positive health changes in individuals is large. Increasing understanding of, for example, the risks associated with cardiovascular disease and effecting changes in lifestyle as a result of that, is a vital and necessary component of primary health care. The interviews with clinic nurses and the narrative reports expanded upon this, noting an increase in patients’ willingness to take responsibility for their health issues and to be more involved in their treatment. This increase in patient empowerment is a significant outcome of the project.

A number of issues impact on the generalisability of this project. The low response rate from nurses working for Maori providers in completing narrative reports means we do not have a complete picture of their experiences and opinions. Similarly, although compliant and non-compliant nurses (with respect to completion of narrative reports) were interviewed, no specific analysis was undertaken to compare the two groups.

Positive changes in workforce development have been another important result. Nurses reported the opportunity and responsibility of providing holistic nursing care, and the skills and knowledge gained from participating in the project were extremely valuable.

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COMPETING INTEREST

None declared.