“WHAT ARE PATIENTS’ PERCEPTIONS OF THE NURSING CONTRIBUTION THROUGH THE MINISTRY OF HEALTH FUNDED SEMI-STRUCTURED PROGRAMME CURRENTLY KNOWN AS CAREPLUS?”

Playing the advantage:
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Researcher interest and background

- CarePlus Coordinator Health Hawkes Bay July 2005-present
- Other related professional roles include: Nursing Council (NZ) Convenor, Professional Conduct Committee, RNZCGP Cornerstone Assessor, MoH Primary Health Care Nursing Expert Advisory Committee member
- Models of long term condition management grew out of PGDip
- Thesis requirement for Mphc
- Ministry of Health intentions July 2007
- Patient narrative
Introduction

- CarePlus - a NZ chronic care initiative
- Funding for extra primary care visits
- Aims to improve chronic care management, primary health care teamwork and reduce health inequalities (MoH, 2004)
- Focus on education, self-management and linkage with related chronic care programmes
Research Aim

- Develop a practical and theoretical understanding of what the patient understands the nursing contribution to be in a NZ chronic care programme (CarePlus)

- To ascertain from patients those elements of the overall nursing contribution they find helpful and why
Background: the literature

- Limited literature on patient perception of nursing contribution particularly in primary care

- Gaps in literature around how patients perceive the role of nurses in long-term conditions programmes

- Most of the literature on patient perception:
  - Older
  - Secondary care based
  - Physician based
  - Nurse specialist/Case management
Literature summary

- **Accessibility, advice, technical support** (Lloyd-Williams et al., 2005; Patterson & Britten, 2000; Phillips et al., 2007; Wiles, 1997; Wright, et al., 2007).

- **Knowledge/social/communication and emotional skills of nurse** (Balint, 1957; Fox & Chelsla, 2008; Lloyd-Williams et al., 2005; Wiles, 1997, Wright et al, 2007).

- **Teamwork and roles of nurses** (Carryer, Snell, Perry, Hunt & Blakey, 2008; Lupton, 2003; Miles, 1991; Robison & Wiles, 1994; Wiles, 1997).

- **Lifestyle advice and behaviour** (Haidet, Krol, Sharf, 2006; Lloyd-Williams et al., 2005; McDonald & Rogers, 2008; Page, Lockwood & Conroy-Hiller, 2005).
Methodology

- Methodology: qualitative, descriptive, interpretive
- Central Region Ethics committee approval:
  - CEN08/24/EXP
- Purposeful sampling
- Individual interviews with patients in CarePlus programme August 2008-July 2009
- Semi structured, iterative depending on respondent responses). Audio taped, transcribed verbatim
- Analysis: Inductive thematic, data management supported by NVivo
- Researcher conflict of interest
14 Participants: summary

- <3 months to 2 years in Care Plus programme
- Ethnicity: Pakeha, Maori, Pacific
- Age: 20 - 80 (majority between 60 and 80 years)
- Employed, unemployed, sickness beneficiary, student, retired

Conditions:
- Asthma
- Hypertension
- Type 1 Diabetes
- Type 2 Diabetes
- IHD
- Schizophrenia
- Asbestosis
- Gout
- Polycystic ovary
Initial (unexpected) finding

- Participants had a limited view of what CarePlus was;
  - Lowered GP fees
  - Initially unsure of purpose of nurse consultation

- Narrow view-initially restricted perception of the nursing contribution
Emergent findings and results

- Patient perception of nurses
  - Interpersonal communication
  - Clinical Support
  - Coaching
  - Self management support
  - Guide/Interpreter
Clinical support

Sub themes:

- Technical skills
- Planning care
- Cholesterol advice, BP/WT monitoring, smoking cessation, pain management, foot care, diet advice
- Early diagnosis, goal setting, follow up care, referral, initiator of clinical programmes
What the participants said about ‘clinical support’

Just mainly watch my weight, which is really down. I was a big person. I was round 130kg. And I was weighed on Monday, which was the third, and I’m down to 98...er, 89.

(Participant 6: 46 years old, New Zealand European Female, >12 Months Registered, Diabetes/Ischaemic Heart Disease)
Coaching

Sub themes:

- Motivator
  - Behaviour change, confidence building, encouragement, nudging, ongoing support, reinforcing.
- Skill development
  - Breaking task down, education, goal setting, help with early diagnosis.
- Assessment activity
  - Follow up care, maintenance.
What the participants said about ‘coaching’

They just went through everything within the first day. But not too much, because ... she could see that I was ... a bit dazed and confused, and going, "Oh my God, this is too much information." So that's why they had me back every day for the week and a bit, to make sure that I was understanding what was going on.

(Participant 13: 32 years old, New Zealand European Female, >12 Months Registered, Diabetes/Hypertension).
Interpersonal communication

Sub themes:

- Communication
  - Answers questions, confidence-building, confidential, talk therapy, filter, listening, affirming, sounding board.

- Attitude/humanness
  - Attentive, available, encouraging, friendly, trusting.
What the participants said about ‘interpersonal communication’

I probably talk to the nurse about more things… And then when you talk to the doctor…about specific things… the nurse is probably more general, and then if there's any problems that she sees, then that's what I would talk to the doctor about [the problems].

(Participant 13: 32 years old, New Zealand European Female, >12 Months Registered, Diabetes/Hypertension).
Guide and interpreter

Sub themes:

- **Guide**
  - Breaking news, help with early diagnosis, breaking the task down, future planning

- **Interpreter**
  - Filter, analyst, judge
What the participants said about ‘guide and interpreter’

… we talked about, goal-setting… And … doing goals. So this is my first goal. We're going to look at weight first…She thought this was a good way to start things, and… then we can look at other things…I thought it was a good idea… because every time I'm going to get weighed, I'm going, "God, I haven't lost anything. I haven't put anything on." I says, "My God, but I know I'm overweight."

(Participant 12: 48 years old, New Zealand Maori Male, Less than 3 Months Registered, Gout/Valve Replacement).
Self management support

Sub themes:

- Self care support – skills and techniques
- Partnerships and teamwork
- Practicing behaviours, care planning, problem solving, self efficacy, skills training, monitoring/managing symptoms, attends appointments.
- Joint decision making, walking alongside.
What the participants said about ‘self management support’

I've been trying … to weigh myself every Saturday morning, before breakfast. I've started doing that again … I bought myself a new set of scales, so that I can read them properly, so that's made a big difference, because I just had a set of scales with a clock sort of thing, and they were hopeless. So I bought myself a digital pair. Now I really know whether I'm going up or down.

(Participant 8: 64 years old, New Zealand European Female, 12 Months Registered, Type 2 Diabetes/Arthritis).
What does this mean for general practice?

Patients limited understanding of CarePlus

Overall:
- Patients feel “guided” through the management of their long term conditions;
- Patients perceive the nurse works with them (intentionally) to determine what they take to the doctor.
So what does this mean about the nursing contribution?

- Deficit in technical support
- Accessibility and sustained contact with knowledgeable nurses with social and emotional skill
- Lifestyle advice and interpersonal communications
- Relational continuity important
- Variation in delivery
Limitations

- Project small and in one geographic location
- Those who chose not to participate may have different thoughts about the nursing contribution
- Data collected from single point in time
- Favorable perceptions cannot be linked to improved patient health outcomes
- Participants all English speaking
- Data collection by nurse
- Limited literature on the actual nursing interventions in chronic conditions management
Recommendations

- Review how general practice explains benefit of CarePlus/frequency of follow up
- Enhance intentional patient centered goal setting and care planning
- Development of nursing competency and capability
- Protocol for follow up and discharge of patients
- Patient advisory
Playing the advantage

- EIT evaluation of Nurse Healthy Lifestyle Clinics
- Purposeful and deliberate nursing consultation by:
  - NursePoint Seminar Series;
  - Development of suite of assessment tools;
  - Nurse sensitive patient outcomes (DRINFO);
  - Structured supported self management;
  - Clinical supervision;
  - Nursing workforce development steering group

- HBDHB Long Term Conditions-Nursing Workforce Development funding/CarePlus reserves.
Conclusion

- Establish what patients value and why;
- Patient understanding of CarePlus is limited;
- Patient motivation to engage;
- Opportunities for nursing development: e.g. sleep, mental health, and pain;
- Patient world view vs: disease screening and monitoring;
- Nurses need clinical skills to plan for right care and communication skills for relational continuity;
- Patient increased confidence - especially when service is recommended;
- Patient preference with specialist need;
- Function of careplan questionable.
References

References

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