Case studies

Following are a number of case studies from the Demonstration Divisions projects that provide examples of how the models were introduced in the general practice setting.

Adelaide North East Division of General Practice Group

Adelaide Northern Division of General Practice Integrated Care Team (ICT) Trial

The ICT targeted several large urban practices in the Adelaide Northern Division of General Practice (ANDGP) region with a view of implementing a trial to measure benefits presented as a result of an integrated approach to chronic disease management.

Coordinated by the Practice Support Manager through the service of:

- Participating general practitioners
- Pharmacist – Home Medication Review
- Practice nurse – care plans, health assessments and clinical support
- Asthma educator – Spirometry and asthma education

One of the first participants to adopt the approach was *ACC,* a large medical practice in the Northern Metro area of Adelaide. *ACC* services a large population in an area classified as low income with a high instance of chronic disease, in particular asthma. The initial visit to the practice by the ICT was to introduce the nine general practitioners at *ACC* to the service and how they may utilise the team to achieve maximum benefits. Members of the ICT introduced their area of speciality including the integration between each area, how to access the service, cost and desired outcomes. Two practitioners and the practice manager volunteered to participate in the trial. For ease of access and tight integration the team was lead by the Practice Services Manager who acts as the central contact for team members and the Practice.

Asthma 3 Plus:

The practice identified 20 asthmatic patients with a recent past history of incident. Ten patients had attended the practice recently, a further ten patients were included as opportunities presented in the next week. The initial patient visit was dedicated to general practitioner consultation; the second consisted of a spirometry session, observation of a medication administration technique and education session. The third visit consisted of a review of medication administration technique and a further education session followed by general practitioner consultation to review the process outcomes with the patient. At the third visit the Asthma 3 Plus item number was triggered. During the process the asthma educator on occasions called on the practice nurse for clinical support (e.g. correct care and maintenance of puffer) or the pharmacist to conduct Home Medication Review in complex cases.

Examples discovered by the asthma educator during this process included:

- A patient produced a puffer full of red dust. The puffer (without the cover) sat on the vehicle dash, close to an open window on a dirt road.
- A patient who “sprayed the puffer around the room to kill bugs”, because the bugs were the cause of her asthma.
- Another patient sprayed the puffer on his chest and rubbed the medication in because the doctor had told him “this is for your chest”.

Medication technique and non-compliance were two common problems identified by the asthma educator. The pharmacist was asked to review several patients due to the complexity of their condition. This was undertaken by an HMR with recommendations communicated to the general practitioner. In one case the pharmacist identified a “home remedy” which included a couple of out of date medications from another family member and a splash of herbs and spices (well it worked for Colonel Sander!). A combined service (in some cases an asthma educator alone, in other cases a combination of two service providers comprising a pharmacist or practice nurse and asthma educator and in the more complex cases all three service providers) worked together with the general practitioner to cover all bases to ensure optimal outcomes for the patient.

The outcomes for asthma patients were varied. In some cases there was a marked improvement in the condition, in other cases a less marked improvement. It was agreed by the providers the service, on a combined front with enhanced service options, was focused with outcomes above expectations. The trial has been expanded by the case study practice to include a further two doctors in addition to one rural practice and three urban practices adopting the service.

Service provider’s comments:

> “Although you know these services are available all the time, the communication and coordination help the delivery process run a lot smoother”.

Asthma Educator

> “I like the option of being able to call on other professionals to assist as the patient’s circumstance unfold” (general practitioner).
>
> “I like to be part of a team approach; we work really well together and have had some outstanding successes” (pharmacist).
>
> “The support and network is very concentrated, I like the idea of working together and having the other professionals on tap, we can work quickly to identify problems and solve them” (practice nurse).

Barriers to the ICT approach to the Asthma 3 Plus Plan:

- Third visit – it is difficult to secure the third visits to trigger the MBS item.
- As patients gain control of their condition they are reluctant to visit the general practitioner for an asthma education session and review visit with the GP.
- Practice staff must be committed to the process. If patients are a no show it is important to make contact and reschedule the third appointment.
- Inappropriate selection of patient e.g. age or incorrect diagnosis. (CPD, not asthma.)

- Keeping the system rotating – it is difficult to maintain the number of patients participating. There is no limit to the number of patients able to participate in the process, but it does require some coordination to maintain a steady flow of patients.

Enablers to the ICT approach to the Asthma 3 Plus Plan:

- Flexible delivery options. One, two, three or more service providers depending on the complexity of the case.
- Provides the patient with the best available care in disease management, education, support and clinical care.
- Reduces the number and severity of incidence due to self-management education, correct medication administration and medication options.
- Reduces the number and severity of incidents due to non-compliance.
- Offers a focused service for the general practitioner to plug into.
- Easy to access—central contact point means service available through central contact.
- Service cost on a user pays basis. The practice can utilise leaders in a field without the cost of direct employment.
- Maintains a system for claiming MBS item for Asthma 3 Plus.
- Provides the general practitioner with secure knowledge the team approach is in a strong position to recognise deficiencies in patient medication techniques, non-compliance issues, or unwise self-medication practice.

Mid North Rural Division of General Practice (SA)

In 2000/2001, the Mid North Division of General Practice, in pursuing funding under the MAHS program, undertook an allied health services needs analysis of all communities across the region. The analysis found amongst a number of specific needs, a common need for practice nurse support to case conferencing and care planning; and asthma and diabetes education and management in a number of areas.

With the development of the MAHS model for the region, the concept of the primary health care/practice nurse was developed. Following a needs analysis a medical centre within the division catchment area sought the services of a nurse who was to be employed directly by the division, at the level of 0.4 FTE (two days per week). With approval for the MAHS project obtained by the division, the processes of implementation commenced, in consultation with the practice.

The Mid North area of South Australia like many similar rural areas around Australia, experiences difficulties in recruiting general practitioners, nurses and other health professionals. Within the local Primary Health Care Nurse model there is a need to ensure some flexibility on the part of the employer, to ensure that work and family time commitment can be mutually met.

The necessary processes required the recruitment of a suitable nurse and it was identified that the incumbent should have extensive experience, including some outreach history and the ability to be well

placed in a practice of significant size and with the ability to self-manage and develop systems somewhat independently of the general practitioners. This latter stated need arose from the need to manage their activity from within a workforce, that was, despite the identified need, treading altogether new and unfamiliar ground.

A suitable candidate was found and appointed in consultation between the division and the practice and appointment was made some seven months after the initial concept was floated. The activity at the Medical Centre is in its third year of operation and provides 15 hours of work per week over two days. The Practice has a patient base of 6000 patients serviced by eight doctors supported by a clinical assistant and administrative practice staff.

The division employed, practice located Primary Health Care Nurse is a new Initiative for the practice. The Primary Health Care Nurse by necessity shares accommodation within the practice as space is limited. Vacant practice rooms and administrative space is provided on a casual basis as the opportunities arise. The primary role for the Primary Health Care Nurse has been case conferencing and care planning as well as chronic disease (asthma and diabetes in particular) education, support and management.

The actual process of recruitment was collaborative, with input from the practice principals and the division. The selection of the appropriate person for the tasks envisaged measured by issues such as clinical competence, experience levels, personality and other factors was perceived to be the prerogative of the practice principals. All of the tasks of advertising, short listing and the administrative processes involved in the determination and agreement of contracts, pay details etc were managed by the division.

The practice nurse like many of her counterparts is a married woman with family commitments, who elected to work part time. This is common throughout the local nursing workforce. The nurse uses accommodation at the practice as a room becomes available. There are no on site meeting rooms so care planning, case conferencing and other consultations in house are achieved through use of vacant doctor's rooms when available. It has been necessary therefore for the nurse to become flexible in her activities.

There were few if any barriers to the development of the proposal to place a Primary Health Care Nurse at the Medical Centre. A key enabler to the activity has been the personality of the incumbent as she has been readily able to work as a team with other practice staff.

A further enabler has been the workload of the practice that is high, with a high doctor to patient ratio and the opportunity arising from the new role to delegate and empower the nurse to assume responsibilities for chronic disease education and support activities. As a result the elderly and those with chronic illness are receiving advice and care that previously occurred only when directly managed by general practitioners when the time and the opportunity arose.

The activity has created alternative employment for nurses in this rural setting, permitting enhanced professional development and satisfaction for the nurses. The Initiative has been embraced by the practice and the community and has filled a gap in services.

Canning Division of General Practice Group (CDGP)

Case Study from the Perth and Hills Division of General Practice (P&HDGP)

Practice Nurse Modelling Tool

Sixty-seven percent (67%) of practices in PHDGP do not have a practice nurse and the issue of financial viability is a major concern for these practices.

The key initiative undertaken by PHDGP over the 12 months has been the development, piloting and implementation of a Practice Nurse Modelling Tool. The tool is an Excel-based IT program that allows tracking and analysis of the roles of general practice personnel and the financial modelling of operations within the division. This tool allows practice personnel to maximize forecasting, budgeting and strategic planning within the practice setting, thus demonstrating the opportunity and financial benefits of practice nurses in general practice. The program also provides a process to assess the impact on personnel and the financial implications of any changes under consideration.

Aim

The aim of the Practice Nurse Modelling Tool in Perth and Hills Division of General Practice is to support and promote the provision of quality nursing care in general practice.

Objectives

- To provide insight into different functions of practice nurses.
- To engage practice staff and discuss options and strategies to enable practice nurses to achieve their full potential.
- To demonstrate the value of the role/s of the practice nurse in terms of opportunity and financial benefits.
- To demonstrate the impact of changing functions of the practice nurse.
- To track the number of practice nurse hours that are required to perform the required functions of the practice.
- To assess the value of Australian Government incentives to general practice.
- To be customised to individual practices.

Description

Data used in the construction of the Practice Nurse Modelling Tool was obtained from the Western Australian Practice Nurse Association, APNA and the HIC. The expanded roles of the practice nurse were based on RCNA's "Nursing in General Practice Information Kit". Further feedback was provided by focus groups and individual contact with practice nurses, general practitioners, practice managers, and division staff. Specialist IT services were engaged to develop and pilot the tool.

The Practice Nurse Modelling Tool is designed as an initial point for investigating the benefits of employing practice nurses. The tool is greatly enhanced by discussions on quality issues and practice systems at individual practices.

While the Practice Nurse Modelling Tool is designed to be customised to individual practices by taking account of many variables, it is impossible to allow for all foreseen and unforeseen variations within practices and individuals. The tool is not seen as a definitive predictor of financial or other benefit and should not be considered as a tool for benchmarking performance.

When first piloting the Practice Nurse Modelling Tool some practice staff perceived that it would be a panacea for all problems within the practice setting. To counteract this, the tool was modified to include an explanation of the tool's capability and limitations and the need for a systematic approach to its use. Additionally, individual follow-up of practice staff piloting the tool was conducted to discuss any change required and how to achieve such change effectively and efficiently in a team environment. Utilising the Practice Nurse Modelling Tool to demonstrate the impact and benefits of practice nurses in general practice was an important component of the implementation process. The Perth and Hills Division Practice Nurse Modelling Tool is an excellent mechanism to engage general practitioners, practice managers and practice nurses in reflecting on the benefits of possible practice nurse roles.

The Practice Nurse Modelling Tool forecasts outcomes in dollar and hour terms. The results should be indicative of the magnitude of the potential benefit but are not absolute. A more accurate prediction of potential benefits for practices can be obtained by entering individual practice data into the tool. If practice data is not available, the Practice Nurse Modelling Tool contains default data obtained from: division, state and national data, practice nurse focus groups, practice managers and general practitioners.

Since the development of the Practice Nurse Modelling Tool there has been much interest in obtaining a copy of the tool. Practice nurses, general practitioners and practice managers within Perth and Hills Division, other state and interstate divisions and international general practitioners have expressed interest in the tool. This widespread interest may reflect the dearth of customised tools that demonstrate the benefits of practice nurses.

Evaluation

A formal evaluation has been performed on the Perth and Hills Practice Nurse Modelling Tool. The evaluation was based on feedback from three workshops attended by six practice managers, five practice nurses and five general practitioners and follow-up practice based evaluations with each participant. The evaluations demonstrated a universal perception by participants for the need of the Practice Nurse Modelling Tool in general practice. The tool demonstrated the possible expansion of roles for practice nurses to 80% of the general practitioners. The workshops facilitated discussion of the benefits of practice nurses between general practitioners who did not have and those who already had a practice nurse.

The process evaluation illustrated that to achieve maximum orientation to the tool, that in addition to the workshop demonstration, a practice-based demonstration was also necessary. Post workshop evaluations are being conducted following the practice-based demonstration to ascertain the staffs' perceived usefulness of the tool.

Feedback has identified that:

- the tool functions well to engage the practice staff team in reflection on what they want for the practice nurse role
- underlying issues in relation to implementing or maintaining practice nurses include role clarification, expectations, and award conditions for practice nurses.

Fremantle Regional Division of General Practice (FRDGP)

Case Study A: General practitioner who has never employed a practice nurse

Dr. A has two general practices in the Perth metropolitan area. He has never employed a practice nurse. "I have never taken the first step. I guess I do not have one by default". However, at the present time he is considering employing one but the task seems daunting to him and he stated without significant help from the division he will probably continue to 'procrastinate'. 'I am just too busy to think about all of the issues, I don't like to hire and fire people and would rather not have to deal with any more stress at the end of the day, despite the fact that I know it could potentially make it easier for me in the long term'.

Previously Dr. A made the choice not to employ a practice nurse with the following issues in mind:

- "I cannot afford one".
- "I like doing all the patient contact tasks such as dressing and immunisation myself".
- "I don't think I would have enough work for them to do".
- "I don't have the physical room in my practice for a practice nurse".

Dr A currently has the following issues to consider

- "Can I afford a practice nurse?"
- "What can a practice nurse do to help me and my practice?"
- "Can I justify having one?"
- "Will the patients be happy with a practice nurse?"
- "Is there enough work for a practice nurse?"

Dr. A has spoken to colleagues who have a practice nurse but is still unclear about what duties they are capable of and how employing one could benefit his practice. He was also informed that initially patients prefer the doctor to continue to do all procedures and that having a practice nurse can be awkward.

What would it now take to employ a practice nurse? *"It would take someone else to help me and basically take that first step".* Despite reading the division's monthly newsletter Dr A was unaware of

the services offered to assist him with employing a practice nurse. Now he has this information he has requested a formal session to update him on the division's role in assisting practices to employ a practice nurse. *"If you had not requested this interview I probably would still not have followed the issue up, at the end of the day I am too tired and just want to go home".*

Case Study B: General practitioner who employed a practice nurse 14 months ago for the first time

Dr. B works in a metropolitan practice with three other general practitioners and two reception staff. The practice is in a low socio-economic area. Dr B has been actively involved in the division, at both a program and Board level for the past ten years and is thus well informed of the services the division can provide, in particular the Practice Support Team.

Despite all the information, knowledge and FRDGP support, Dr B has only decided in the past 14 months to employ a practice nurse. What have been the issues for Dr. B? Why has he not employed a practice nurse prior to this despite knowing the enormous benefits a practice nurse would bring to his practice?

A face-to-face interview with Dr. B provided wonderful (although not unique) insight into the issues general practitioners contemplate before employing a practice nurse. One of the main reasons Dr. B employed a practice nurse was to 'take some of the pressure off'. He also thought that there were many things the practice should have done and didn't because the doctors didn't have time. Like many of his colleagues, Dr. B waited until his stress levels were close to crisis point. Dr. B also reported that "trying to maximise finances for the practice as well as providing a better service for his patients" were motivating factors for him to employ a practice nurse and 14 months later, Dr B cannot believe he did not do it sooner. He has no negative experiences to report.

Dr. B admits that he is not using his practice nurse to her full capacity. He believes that he is still too busy and does not have time to "sit down and smell the roses". For him, making time to stop and re-evaluate the roles and responsibilities of his practice nurse is not seen as a current priority, nor does he see it as an activity that can further maximise the effectiveness of his practice. However, Dr. B does realise he will need to address this at some point in the future.

At present, Dr. B is happy with the way his practice dynamics have changed and his relationship with his practice nurse. "Nurse B knows my idiosyncrasies. She helps monitor the patients and keeps us all going. She knows when we might need a coffee break or an extra pair of hands. The patients are very positive about Nurse B being in the practice. You just cannot put a value on the extra pair of hands. We notice when she is not there. I just don't want to do it by myself anymore".

Case Study C: General practitioner who has always employed a practice nurse

Dr. C is a metropolitan area general practitioner who works in a large corporate practice with 12 other general practitioners and four practice nurses. Previously Dr. C worked in rural practice where he always employed practice nurses. "I have always been in practices with a practice nurse. They are an essential expense and an asset to any practice. General practitioners who do not have them are

money pinching. I think practice nurses are far more skilled at completing tasks such as immunisation, weight, height, BP check, blood sugar checks, and spirometry than us."

Working with practice nurses is part of Dr. C's daily routine in his practice. He believes that those general practitioners with a nurse are at a real advantage. "The first thing is that it gives you more time with patients. The patients can talk about the issues that brought them to you for the whole appointment time."

How would he advise other general practitioners who are considering employing a practice nurse? "Do it. You will never regret it. They add so much to the practice. There is a big medicolegal advantage. You have another medical person keeping their eyes on and monitoring the patients."

General practitioners are often concerned about what the patients think about not having a doctor attend to all of their medical needs. Dr. C strongly believes that his patients enjoy having a practice nurse. "They absolutely love it. Some come back on specific days just to see a specific nurse. Some would be okay to see the nurse only but unfortunately this is not cost effective the way the MBS is structured."

How best could the division express to other practices the benefits of having a practice nurse? "We need to get around the cost some how. Doctors will not know until they try it. They should discuss it with their colleagues who have a practice nurse." The following points regarding employing a practice nurse were highlighted from the face-to-face interview with Dr C:

- Face-to-face contact with general practitioners is beneficial.
- Address the cost factors, illustrate how a practice nurses can be a self-funding prospect.
- Listen to other general practitioners who have a practice nurse.

Hunter Urban Division of General Practice (HUDGP)

Case study: Practice Nurse Recruitment

Solo practitioner: Urban practice

Standard Whole Patient Equivalents (SWPEs) – 2300 with many family groups.

In the first roll out of the Practice Nurse Incentive Payment, the practice did not qualify for the incentive. However, the HUDGP approached the practice to see if they were interested in employing a practice nurse. The practice was interested and identified the role the practice nurse could take identifying immunisation, diabetes and women's health as the main areas of need.

The general practitioner knew of a registered nurse who was working in another area and he approached her to work 16 hrs/ week. She accepted the offer. The registered nurse was an accredited immuniser.

Initially the practice nurse saw patients on demand and as directed by the general practitioner but within three months they soon realised that the practice nurse would work more efficiently with her own appointment system so the following model was developed

GP	PN
GP pt 15 mins	PN pt 20mins
PN pt 5 mins	
GP pt 15 mins	PN pt 20mins
PN pt 5 mins	
GP pt 15 mins	PN pt 20 mins
PN pt 5 mins	
Total 3 pts	Total 3 pts

The general practitioner paid for the practice nurse to complete the Family Planning Australia Women's Health Course and on completion the practice nurse undertook all breast checks, pap smears, and contraceptive advice with support from the general practitioner.

As the number of practice based patients grew, and as the practice nurse had a young family and didn't want extra hours, the general practitioner employed a second practice nurse for 20 hrs per week. The practice nurse was a qualified diabetes educator.

Both practice nurses undertook EPC health assessments, wound care and immunisation.

After a 12-month period the general practitioner identified a need to provide extra support for patients attending with a mental health related problem e.g. depression, postnatal depression, grief and loss. In conjunction with the Hunter Area Health Mental Health Team, a mental health registered nurse who was interested in working in a practice environment was employed one day per week maintaining her area health position for the other four days.

The Practice Mental Health Nurse works five hours per day with the following model:

GP	MHN
GP pt 15 mins	MH pt 45 mins
GP pt 15 mins	
MH pt 15 mins	
GP pt 15 mins	MH pt 45 mins
GP pt 15 mins	
MH pt 15 mins	
GP pt 15 mins	MH pt 45 mins
GP pt 15 mins	
MH pt 15 mins	
GP pt 15 mins	MH pt 45 mins
GP pt 15 mins	
MH pt 15 mins	
GP pt 15 mins	MH pt 45 mins
GP pt 15 mins	
MH pt 15 mins	
Total 15 pts	Total 5 pts

This model frees up the general practitioner to see more patients per hour. The practice now qualifies for the Practice Nurse Incentive Payment with the availability of six sessions.

They also have a pharmacist attend the practice one day per fortnight to undertake the Home Medication Reviews, and a dietitian attends one day a fortnight to contribute to diabetes care planning and to see non-compliant diabetics.

Northern Tasmania Division of General Practice (GP North)

The Introduction of the Practice Nurse Concept to a General Practice

The strong driver behind GP North's Practice Nurse Program in 2000 was the introduction of the EPC item numbers by the Australian Governments DoHA, although by this time GP North via its membership had already identified the importance of practice nurse support, as beneficial to its members and general practice as a whole.

The introduction of these item numbers was viewed by the board at GP North as an invaluable opportunity to promote the integration of practice nurses into general practice and provided an excellent impetus to do so.

Additionally, GP North saw the potential benefits of being able to offer the membership practice nurses on a contract basis, which removed the fears of sustainability of employment, which at the time was viewed as a major barrier holding back general practitioners from taking the leap to integrate practice nurses into their practice. It was also considered that apart from practice nurses, the membership could benefit from being offered a broader range of services on a contract basis, such as secretarial and practice management. For the provision of such services, a subsidiary company with its own board of management was established.

The benefits of employing a practice nurse was presented to the membership via a combination of educational evenings focusing on the EPC item numbers and the role of the nurse in their access, as well as individual presentations delivered by GP North's Chief Executive Officer to practices and practitioners. Apart from the financial benefits, broadening of services offered, and improved patient outcomes resulting from integrating a practice nurse to the practice, members were made aware that the division's contract nursing service would provide them with highly experienced nurses, most of which had held senior nursing positions in their previous employment, and had been fully orientated to general practice using divisional resources and expertise.

The contract nurses were well versed in the new EPC item numbers and were provided with portable notebooks (laptop computer) and EPC templates which would see minimal or no disruption to the practice, whilst the nurse's new role in the practice was being developed. Additional orientation to general practice was provided to the newly employed nurses by divisional staff that held expert knowledge of the workings of general practice.

General practitioners were also offered the opportunity to visit other practices that employed practice nurses to see them in action and see how they could be utilised to enhance the practice and reduce the general practitioner workload.

Once the individual practice had made the commitment to employ a practice nurse via the division, a lunchtime meeting between the division's nurse coordinator, the nurse and the potential employer was held, so all parties could meet and discuss their actual/ potential role and expectations. A trial period was also set to ensure all parties were happy with the arrangements, and regular communication ensured that any arising issues were dealt with. It was also decided that to allay any reservations of over-commitment, the practice could begin by employing the nurse for one day a week only, with the

option of increasing their hours as their role was developed. In one example, a nurse was employed by a practice that had never had the services of a nurse before. It was a 3 FTE general practitioner, RRMA 3 general practice.

The nurse began by undertaking only EPC health assessments, one day per week. In the first month alone, over a dozen occupational therapy referrals were made, with obvious positive patient outcomes such as the installation of safety aids in the patient's home and the identification of various other risk factors, such as deficient dietary intake or poor medication compliance. Additionally a number of other referrals were made to allied health care providers ranging from podiatrists to Medi-alert services.

In on going discussion with the general practitioner employer, the nurse was soon able to show the employing practice, the various other skills they brought with them, such as the ability to undertake certain aspects of accreditation work, cold-chain management, triage, mediation with other health care providers, stock management, sterilisation, assistance with and undertaking of clinical procedures, and provide broad support to the general practitioners as required. The role of the nurse soon developed further and the nurse was contracted two days a week by the second month of employment.

The increased range of services provided by the practice as a result of employing a practice nurse saw the purchase of electrocardiography and spirometry equipment, the purchase of emergency equipment, including that required for emergency intubation and defibrillation. The surgery began nurse led asthma, diabetes and dietician clinics, allergy testing, broadened immunisation services, and for patients with complex and chronic conditions, various care plans were formulated and some case conferencing attended.

The number of surgical procedures undertaken at the practice also rose by four fold, as the general practitioners no longer had to allow time for the preparation of equipment and clean up. Additionally sterilisation was now the responsibility of the nurse who also introduced a tracking system. This marked the beginning of various quality assurance programs initiated by the nurse with the support of the practice team.

By the third month of employment, the nurse's hours were increased to three days per week and the general practitioners in the practice claimed to find the services of the practice nurse invaluable and somewhat indispensable. They found that the capacity of the practice to provide expanded services and embrace change had markedly increased, while their overall workload had decreased.

Although the initial underlying premise for employing a practice nurse was to access the new EPC items, the role of the nurse was broadened and became quite comprehensive in a very short period of time. The experience of the division's Nurse Employment Service has been that however the nurse is integrated into the practice initially, for example be it to provide a 'specific' service only such as EPC health assessments, there appears to be a rather speedy natural progression of the nurse's role within the practice.

Another observation made is that the introduction of the "Practice Nurse PIP" appears to have partially removed the 'pressure' on the practice nurse to generate enough income to 'justify' their employment, allowing the practice nurse to undertake extremely important work within the practice that does not necessarily attract obvious financial return. The new nurse item numbers have also been well received.

We view this example case study as classical of our experience of integrating nurses into general practice. Four years down the track this particular nurse is still employed by this practice and is considered an invaluable member of the 'team'. This result however is not guaranteed; there must be

willingness from the general practitioners to delegate aspects of patient care and learn to function as part of a team. In instances where this has not occurred either the nurse is no longer employed by the practice or their role has not developed as it could have, leading to poor job satisfaction.

It should also be noted at this time that the introduction of our nurse contract service provided the platform for a broader 'practice nurse support program' which we believe is an integral part of ensuring the sustainability of the general practice nurse workforce.

South East NSW Divisions of General Practice Group (SENSW)

A rural general practitioner who has never employed a practice nurse

Dr T is a rural GP whose practice is one of three in a small rural town. He has considered employing a practice nurse however has seen taking the step to do so as one of great difficulty. Following is an outline of that discussion.

"I have considered sharing a nurse with Dr K but never got around to it" While the doctor realises the benefits of employing a practice nurse he cited a number of problems that stand in the way:-

"I don't have enough room. Space is a problem that would need to be addressed. Maybe the nurse would have to come when I'm not here. It isn't such a problem for Dr K as he has more space".

These issues not withstanding Dr T was certainly aware of the benefits to his practice in employing a nurse. "I know that employing a practice nurse would help me manage my workload more effectively and I'd have more time to spend with the patients. I might even finish surgery at a reasonable time. It wouldn't cost that much either."

Dr T saw another problem "I'm not sure when I should have the nurse here; the patients she could see don't always all come on the one day".

Further discussion about the role of practice nurses assisted Dr T to clarify the duties that a practice nurse could undertake.

How does Dr T now feel about the possibility of employing a practice nurse? "Maybe I need to talk with Dr K about sharing a practice nurse and someone could help us find someone suitable? I still would have to workout the issue of space".

Case study two

A group of general practitioners on the South Coast of NSW who did not employ practice nurses became convinced as to the benefits that could be afforded to their practice should they employ a practice nurse. The practice nurse originally employed was made available to this practice from the division free of charge. As the benefits for the practice in the way of assistance with clinical tasks such as conducting spirometry, ECGS, undertaking dressings, became evident the practice became more

open to the idea of having a practice nurse in their own right. The additional benefit of increasing income for the practice by way PIP and EPC Initiatives also helped to see the position grow.

Southern Metropolitan Region Divisions of General Practice (SMRDGP)

Background

As a group, the SMRDGP Regional Practice Nurse Support Network has undertaken a number of region-wide projects. These include:

- a research project exploring the role of the practice nurse in EPC, especially health assessments.
- information and orientation to general practice sessions for nurses working in other sectors.
- establishment of a database of available nurses—providing an advertising service for practices.
- regional professional development workshops for practice nurses.

Each of the seven divisions within the SMRDGP continues to undertake its own autonomous program of support to practices and nurses, maintaining a local focus with activities tailored to each division's unique needs and priorities. The following case study gives an example of how the regional activities translate into local practice-based outcomes.

The practice

The practice has two general practitioner principals plus several part time associates making up a total of approximately six FTE general practitioners. The practice had previously employed a nurse for one session per week to undertake home-based annual health assessments only. One of the principal general practitioners had been considering employing a nurse for some time; he had obtained some information from the division some months earlier, then followed up for further advice and a meeting was arranged between himself, his partner and the division Program Officer.

One purpose of the meeting was to convince the other principal that a nurse would benefit the practice. This general practitioner did not want to create a new position from existing tasks that were already being undertaken competently by other staff members. He was reluctant to fund a new position unless it would clearly add value, and revenue to the practice.

After discussing the practice patient profile, general practitioner workload and administrative responsibilities, it was identified that the practice was not accessing some components of the Chronic Disease Management PIP incentives, and missing opportunities under the EPC program.

It was identified that a new nurse could (two-three sessions per week initially) be responsible for home health assessments, setting up a system for recalling women for Pap tests, undertake diabetes assessment and education and provide wound care. There was potential for the hours and role to increase according to the nurse's level of skill and competence, to include asthma education and

spirometry, audiology, ECGs, immunisations and record keeping, general recall management and care planning/liaison with other services.

The general practitioner then prepared a position description to reflect these roles and responsibilities, which was distributed by the division to the nurses on the regional database.

The practice received approximately five applications. They interviewed a number of these and offered the position to one. The general practitioner also sought advice from the division on an appropriate level of pay.

The successful applicant had attended one of the three Information Sessions and the Orientation Day held by the Southern Metro Region divisions, so was well aware of the services and support provided by divisions to practice nurses. She contacted the local division and requested a number of resources that would assist her in the new position. She met with the Immunisation/CDM Program Officer who provided her with information about the EPC items and the Chronic Disease PIP and the process for immunisation reporting and other immunisation resources. She also had a training session on Medical Director with the IMIT Program Officer and has been given the names of several practice nurses in the area to which she can turn for advice once she starts the new position. All of this was prior to actually commencing the job!

She has now registered with the division's Practice Nurse Network, so will receive invitations to any educational activities offered, and has been informed that practice nurses are welcome to attend general practitioner Continuing Professional Development events that are relevant to her role. She has already attended a two-day Diabetes Update workshop, organised by the division network in conjunction with the International Diabetes Institute.

Mornington Peninsula Division of General Practice: supporting 70 practices.

The practice nurse and practice manager networks were set up six years ago with terms of reference to provide a forum for exchange of information and ideas for the division to support each separate network.

Each group wished to be the driver of their own agenda and initially a needs survey was undertaken to identify topics for discussion in the first twelve months. For each group a top ten was selected and the divisions proceeded to identify and recruit high quality speakers for each topic. This worked well on limited resources.

With the advent of accreditation for general practice a new dimension was added—the division decided not to appoint or resource an individual at the division to support accreditation rather to upskill a group of practice managers/practice nurses/general practitioners who were interested in accreditation and had participated in preparation for accreditation at their practice.

This group was to be supported by the division to go out and visit practices and create inter practice relationships and peer support. The group was provided with some training by Australian General Practice Accreditation Ltd (AGPAL) at the division and a number of division resources, and were soon visiting practices giving advice on division resources available and sharing their knowledge and support. All involved enjoyed this phase of operation.

The division provided support and ongoing upskilling through the two AGPAL surveyors within the division's boundary (one general practitioner and one practice manager). It continues to support, provide resources, kits and guidelines to assist practices achieve accreditation and reaccreditation.

The two networks meet regularly, still drive their own agenda but enable the division to leverage on these forums to talk about how its programs can assist the practice nurse, practice manager and general practitioner to improve the quality of general practice. Regular annual and ad hoc feedback provides information on future meetings, topics, speakers, and liaison. We are still thriving and the Board and members fully appreciate the networks and support them by ensuring resources and expertise are available through the division.

Hospital-based upskilling for practice nurses

To enhance training and education opportunities the division negotiated with the acute sector (Peninsula Health) to provide access to hospital based in-service training for nurses to the broader audience of practice nurses. Often these in-service training sessions were conducted during the day, or in the evenings and suited practice nurses. Initially there was no cost for this training however there is now a small cost involved for non-hospital attendees, which is accepted by general practice.

This has built relationships, support and understanding of the practice nurse role at the acute interface and has provided high quality structured education programs. Some examples have included a SARS update. This provided a timely workshop also providing an opportunity to exchange information and understanding on how the acute/primary care sectors were to deal with SARS. Other examples have included wound management, infection control, ECGs, and numerous other topics.

Townsville Division of General Practice (TDGP)

TDGP Practice Support Incentive 2002 (TDGP PSI 2002)

Due to Medical workforce shortages in Townsville, resulting practice fatigue, and the lack of resources to effect change, TDGP Board decided to use newly allocated Chronic Disease Management (CDM) funding, up to $30,000, to trial an initiative design to provide practice support at the grass roots level. Feedback from practice managers had indicated that the majority of practices would experience additional workloads associated with the setup of the information systems disease registers and active recall mechanisms required to support service incentive and outcomes payments. Thus, the division decided to assist all interested Townsville practices to set up the internal systems required to make the most of the new Practice Incentive Payments.

A payment of $300 per FTE GP was made to applying practices. This incentive was to be used to buy extra nursing/staff time to meet critical needs within the practice.

Seventeen practices with a workforce of 65.2 FTE GPs (79% of FTE general practitioners) sought the incentive as a result of considerable marketing. In total $19,560 was allocated under this proposal.

The applying practices identified the following needs to be addressed:

- Practice accreditation—improving quality and standards in the practice (one)
- Australian Childhood Immunisation Register reconciliation's (four)
- Develop and improve diabetes and asthma registers (nine)
- Data cleansing—computer and manual records (five)
- Up skill staff and systems to utilise EPC items (four)
- Coordination of recalls (three)
- Data collection improvements (one)

Most practices that accepted the PSI2002 wanted to access the PIP and Service Incentive Payment (SIP) funding and used the funding to buy extra nursing time. This time was spent:

- identifying asthmatic and diabetic patients and women who had not had a cervical smear for >four years
- data cleansing of demographic information, clinical diagnoses and immunisation data
- upskilling of nursing staff on current diabetic and asthma treatments and assessments

The participating practices were asked to provide the following reports:

- initial status (<50 words)
- procedures undertaken (<100 words)
- impact outcome i.e. immediate outcome (<100 words)
- outcome after three months (<50 words)

As a result of the incentive funding, general practitioners and nursing staff were able to identify critical issues and address them. The following are examples of such issues:

- **Data cleansing**: Electronic chart numbers in a practice ended with B or H and these needed to be appropriately archived to enable the practice to identify their current practice population.
- **Improved record keeping**: A solo general practitioner had just relocated to a manual record practice and wanted to computerise the records. He had purchased two computers but did not have the skills to network them or to get the clinical software operating. The small payment enabled him to subcontract the North &West Qld Primary Health Care IMIT officer to meet these needs. (TDGP policy at this time did not allow our IMIT officer to perform this role)
- **Consolidation of manual records**: Another new general practitioner had purchased an existing surgery, which then had three types of manual records. The payment for 1.3 FTE general practitioner enabled practice staff (at that stage they did not have a practice nurse) to reconcile their manual systems to one type.
- **Development of diabetic registers**: Most practices that accessed the TDGP PSI2002 used the payment to develop chronic disease registers enabling them to access PIPs and SIPs. TDGP assisted practices to identify the maximum number of patients by developing a Microsoft Access

query tool, which interrogated pathology, prescriptions and diagnosis. Some practices increased the number of identified diabetics from ten per cent to nearly double in one practice.

Where backfill was used, practice nurses had the time and resources to work on the issue without trying to squeeze it in with normal duties. At the same time they learned how to use staff effectively in identifying and addressing an issue.