

**Nurse Practitioner-led care in long-term aged care facilities in New Zealand: An exploratory  
study of registered nurses' and general practitioners' perspectives**

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To be a nurse means to have the skills and science to care for people who cannot care for themselves; to assist people to cope with disability or the effects of pathological processes. Thus, I am less impressed with the nurse who can determine that the patient is 'throwing PVC's' than I am with a nurse who can get a frightened confused patient to eat. One of the reasons the general public and legislators seem to assume that nurses' aides must do most of the care in nursing homes is due to the fact that many in the nursing profession itself have lost sight of what nursing really is. We have undersold the degree of skill involved in 'taking care of'—in nursing—people. I believe we need to refocus, and the long-term care situation in this country is one of the settings that might clarify our role for us, if we are willing to get involved. (Schwab, 1997, as cited in Touhy, 1997, p. 5)

## Abstract

There are many issues facing long-term aged care facilities in New Zealand, which will have future implications: the increasing complexity and dependency of residents; the aging population; restraints placed on the workforce such as funding, availability of registered nurses and general practitioners, and skill mix of staff; and legislated/policy requirements, are resulting in increased intensification of their workload and placing further pressure on an already overburdened workforce. It is known that the registered nurses and general practitioners are struggling to meet needs of the residents, resulting in moral distress.

The purpose of this research was to explore if the nurse practitioner role in long-term aged care facilities in New Zealand would be supported as a model of care by registered nurses and general practitioners. A descriptive design was used to survey registered nurses and general practitioners, who were also invited to participate in phone interviews. The majority of questions in each survey remained the same for both groups; however, some questions were altered to accommodate the difference in roles. The survey was made available electronically via Survey Monkey™.

Although both cohorts were favourable to the nurse practitioner role and saw the nurse practitioner as reducing the general practitioners' workload, assessing and treating residents in a timelier manner, and supporting registered nurses in various aspects, long-standing concerns around the nurse practitioner role remain. Issues regarding the availability and funding of the nurse practitioner continue, particularly in an area where funding is limited. The majority of registered nurses and general practitioners were of the opinion that the services of a nurse practitioner would enhance delivery of health care in long-term aged care facilities, that nurse practitioners could improve access of care to residents in long-term aged care facilities, and that the registered nurses and general practitioners indicated their willingness to work in collaboration with a nurse practitioner. Both groups saw the nurse practitioner role as being a collaborative role with the general practitioner.

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## Summary of Abbreviations

Complete Name	Abbreviated Text
aged care education	ACE
aged residential care contract	ARCC
annual practicing certificate	APC
chronic obstructive pulmonary disease	COPD
clinical nurse manager	CNM
clinical nurse specialist	CNS
critical social theory	CST
district health board	DHB
emergency department	ED
enrolled nurse	EN
enduring power of attorney	EPOA
full time equivalents	FTE
general practitioner	GP
Health and Disability Commission	HDC
Health Practitioners Competency Assurance	HPCA
identify, situation, background, assessment, and recommendation	ISBAR
indwelling catheter	IDC
internationally qualified nurses	IQN
intravenous	IV
long-term aged care facilities	LTACFs
Ministry of Health	MoH
New Zealand	NZ
New Zealand Nurses Organisation	NZNO
not for resuscitation	NFR
nurse practitioner	NP

Nursing Council New Zealand	NCNZ
Organisation for Economic Co-operation and Development	OECD
per oral antibiotics	POAB
primary health organisation	PHO
pro re nata	PRN
registered nurse	RN
The Royal New Zealand College of General Practitioners	RNZCGP
urinary tract infection	UTI

## CHAPTER 1

### Introduction and Background

Care of the older adult is a topic of interest in contemporary health care discussions, with increasing demands being constantly placed on residential care facilities to provide cost-effective care in the face of increasing financial constraints and a steadily increasing ageing population across the Organisation for Economic Co-operation and Development (OECD) countries ("Trends Shaping Education", 2008; United Nations, 2013). Ergas (2012) notes that there is already a burden on the taxpayer as the primary source of funding for aged care, and with the current increase in age-related health requirements, this burden is set to increase even further. As Ratcliffe et al. (2010) contend, this change in age-related health requirements creates a situation where the financial resources available to aged care services can influence the clinical decision-making and subsequent care of the residents.

This research<sup>1</sup> has its beginnings in a long-term aged care facility (LTACF) when the author realised the overwhelming pressure and accountability placed on Registered Nurses (RNs) and General Practitioners (GPs) to provide quality care to residents in the LTACF. The difficulty for RNs and GPs to provide quality care to residents has largely been attributed to the increasing complexity of the residents; the challenges of working with an unregulated workforce; the inexperience of some RNs and the struggle for GPs to review residents in a timely manner. The isolated role of the RNs, combined with the rising level of responsibility and accountability related to resident acuity and the corresponding growing demand of the workload has further attributed to this situation. Whilst these challenges have been experienced by the author, international studies suggests that factors such as these do influence the quality of care provided to the residents (Haines et al., 2013; Jacobs, Lilly, Ng & Coyte, 2013; Konetzka Park, Ellis & Abbo, 2013).

When considering the factors that create challenges to both the workforce and care provision, there comes a constant need to work smarter. One such nursing role that is evolving as a partial solution to factors that affect care provision is the Nurse Practitioner (NP) because of their ability to encompass integration of care across health care professional and service boundaries (Clark, Parker, Prosser & Davey, 2013). The NP role has a scope of practice that affords both the authority and the knowledge to work with specialist populations groups in co-ordinating care, a role that has been found to provide effective support to care and economic sustainability (Clark et al., 2013; Nursing Council of New Zealand [NCNZ],

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<sup>1</sup>For the purposes of this thesis, the term research refers to the current work whereas the term study refers to the work of others.

2012). Although the literature provided evidence of their effectiveness, NPs are still not being embraced in the aged care sector, as a model of care that could support cost-effective care (Clark et al., 2013; Ornstein, Smith, Foer, Lopez-Cantor & Soriano, 2011).

This thesis, therefore, set out to explore the perceptions of GPs and RNs of the NP-led care in New Zealand (NZ). Although the focus of the research was on the perceptions of the NP role by RNs and by GPs, it soon became clear that all of the abovementioned factors were impacting on both the RNs' and the GPs' ability to provide what they deemed as quality of care. The survey and interviews thus became an intense process of information sharing related to workload and challenges linked to the provision of care within the facilities in which they worked. Within this, their perceptions of the NP role featured as emerging solutions weaving between their recounting the issues they face on a daily basis. As a result, the data gathered for this research became far greater than was originally anticipated. Although it is acknowledged that the length of this thesis is somewhat lengthy, the data extrapolated and discussed, is considered highly relevant to the research questions, as it highlights the issues RNs, GPs, and LTACFs currently face in NZ.

The NZ older adult population (65 years and over) is growing significantly (Foster et al., 2012; Kerse & Boyd, 2010; Ministry of Health [MoH], 2013b.), and life expectancies are also increasing (Bagshaw et al., 2009; NCNZ, 2013). Despite the longevity of the population, Carryer, Hansen and Blakey (2010) found that altered diets, sedentary lifestyles, and hypertension contribute to the changing health care needs related to chronicity that are additional to the ageing process, adding a further strain to the competing health care demands that are placed on aged care provision, against the costs of that care. The acute services of District Health Boards (DHB), which are managing acute episodes of chronic disease, are also under strain amidst reduced costs that are the result of decreasing the number of available beds as well as reducing the average length of stay of all patients, all of which impact on older adults requiring long-term care (Malcolm, 2007). The decreased costs from the reduction of available beds and bed use can be maintained if, as Malcolm (2007) states, attention is also given to reducing hospital admissions, for example, managing the needs of minor acute presentations in the community rather than at the hospital. Bagshaw et al. (2009) state that the admission rates into hospitals for the older adult population with acute illness will increase because "older age is associated with an increased prevalence of chronic illness and function impairment" (p. 2). Focusing on primary care settings for managing care, and reducing the primary care settings use of the hospital services, especially for older adults acutely admitted to hospital, may be a way to reduce hospital admissions as shown in a Christchurch study

(Malcolm, 2007). With the reduced length of stays in hospitals due to limited bed numbers, earlier discharge from hospitals will continue due to the demand of beds. Earlier discharges from hospital can have a domino effect on LTACFs because of increased pressure on LTACFs to admit and care for people who are discharged earlier but require ongoing care, which results in a greater demand being placed on LTACFs, and the staff working in them because of the high acuity of patients within them (Carryer et al., 2010).

These issues, combined with a documented shortage of GPs (Carryer et al., 2010; Lowe, Plummer, & Boyd, 2013), suggest that improved methods of care delivery should be explored for the care of older adults in LTACFs.

The objective of the research, therefore, was to determine whether the NP-led role in NZ LTACFs would be supported as a model of care by RNs and GPs. The aims were to explore ways to improve access of care for residents residing in LTACFs by

- understanding the demands/workloads of RNs and GPs and explore their views and how they could be supported in the care provision using extended nursing roles
- determining if the perspectives of RNs and GPs working in aged care regarding NP-led care in LTACFs in NZ differ from each other and the reasons for this
- identifying factors that influence the RNs' and GPs' perspectives regarding NP-led care in LTACFs in NZ
- making recommendations based on these perspectives regarding NP-led care in LTACFs in NZ

### **1.1 The research question**

“What are the perspectives of registered nurses and general practitioners regarding nurse practitioner-led care in long-term aged care facilities in New Zealand?”

### **1.2 Significance of the research**

With the changing face of aged care and the increasing demands placed on an already burdened workforce, this research adds a different viewpoint to the literature available, in that it provides researchers with insight into the challenges RNs and GPs in NZ face and their perspectives about the NP role in aged care in NZ. With the increase in the older adult population, not only are RNs needing to reflect on their scope of practice, but the number of available GPs remains limited and, in some cases, is declining (Carryer et al., 2010). The decreasing number of available GPs together with the increasing complexity of aged care

needs and dependency, a more streamlined approach to providing health care to these residents in LTACF is timely.

### **1.3 Conclusion**

In the next chapter, the research that examines aged care provision in NZ and internationally is explored.

## CHAPTER 2

### Literature Review

The objective of this research is to explore the perceptions of RNs and GPs regarding NP-led care in NZ. There are many issues currently facing the aged care sector. A known decline in GP numbers and a rise in an older adult population that is also increasing in dependency and complexity making it difficult to meet the needs of this population. To determine if NP-led care in LTACFs is a possible model of care, viewpoints of RNs and GPs were explored. Furthermore, factors that may influence these perspectives, such as patient demographics and workload, also need to be explored. Prior to commencing this research, a literature review was undertaken to gain an understanding of what research was available on this topic.

To understand if there is a role for an NP in aged care, research into the environment and workforce related to the older adult population and LTACFs was required. Since the role of the NP in NZ is relatively new, there is little literature to support the research in this country. Therefore, the search was extended to other countries, with a timeframe of 60 years given that the role was first implemented in the United States of America in the 1960s. The literature considered relevant to this topic was divided into various themes, which will frame the discussion. The search of literature was comprehensive to ensure any literature that related to the current issues facing aged care were reviewed. These included the effect an older adult population had on health care services, barriers to care for RNs and GPs, the NP role and its place in aged care, and previous perspectives of RNs and GPs regarding the NP role. In order to find this literature, search terms used were aged care, older adult, rest home, long-term aged care, long-term care, continuing care, residential care, nursing home, emergency department (ED), accident and emergency department, Registered Nurse, General Practitioner, physician, Nurse Practitioner, perspectives, viewpoints, and quality of care.

#### **2.1. Growth and increased complexity of the older adult population**

It is well known that, in NZ and internationally, the older adult population over the age of 65 years is increasing due to advances in medicine that is contributing to people living longer (Philips et al., 2006). The increase in the older adult population is impacting on the health care system (Zeitz et al., 2010). Given the complexity of the older adult, Clark, Parker and Davey (2014) stated that the cost to the health care system for those above the age of 65 years was four times higher than those below the age of 65 years. As far back as the 1980s,

the impact that the rising acuity of the older adult population has on LTACFs has been studied (Stull & Vernon, 1986). As people are living longer, the growth of the older adult population is leading to care that is more complex due to increased co-morbidities and this has increased costs of health care provision. The increased complex care is also requiring increased time and efforts from staff to meet their needs (Kubicek, Korunka & Ulferts, 2012). Furthermore, the longer life expectancies are also causing people to make "difficult decisions that were irrelevant only a generation ago" (Pruchno & Smyer, 2007, p. 1). With the increase in longevity comes what Pruchno and Smyer (2007) suggests is first protracted functional decline in what Pruchno and Smyer (2007) call "compressed morbidity" (p. 3) and secondly that there will be an increase in people who will have dementia. With the aim of decreasing pressures placed on the hospital system, the Australian Government in 2007 began to reform the health care system with the intention of improving primary health care, commencing with the aged care environment. One of the initiatives to strengthen primary health care was to support the NP role and to change legislation that had previously restricted their role (Clark et al., 2014).

As already indicated, older adults are being admitted into LTACFs with complex needs and an increased acuity (Langer, Drinka & Voeks, 1991). The increased complexity of older adults was supported by Philips et al. (2006) who stated that residents were "sicker, and have higher levels of disability and fragility" (p. 419). With the increase in age, there was found to be an increase in disability (McKenzie-Green, 2003). Older adults who lived in LTACFs frequently had multiple disabilities, with increased difficulties in areas such as mobility, impaired senses (hearing and vision), cognition, completing activities of daily living, and speaking (McKenzie-Green, 2003). It would be logical to say that aged care requires a more specialist approach to a workforce to care for these complexities. Of concern then is the issue currently facing NZ and Australia is recruiting and retaining a workforce to meet the needs and demands of the growing aged care sector (Kaine & Ravenswood, 2013). In order to meet the demand that will be placed on the aged care sector in Australia alone in 2050, Kaine and Ravenswood (2013) estimated that the current workforce in aged care would need to expand at least four times its current size. This estimate supports the argument made by Dall et al. (2013), who identified the need for a larger and more specialised health care service workforce to care for older adults in the future. Furthermore, O'Halloran, Britt and Valenti (2007) found that the types of GP consultations that took place in LTACFs differed from the types of consultations GPs undertook in their practice. Reasons for these differences were

quoted as "some of the chronic diseases managed by GPs in RACFs<sup>2</sup> are associated with profound or severe activity restriction in older people" (p. 90). It was also identified that most common conditions encountered by the GPs in the LTACFs were stroke, congestive heart failure, dementia, and osteoarthritis.

## **2.2. The broadening scope of services offered**

In response to the increasing complexity of conditions that are presenting in aged care facilities, so too are the type of services offered within it, changing. Palliative care is becoming increasingly common in LTACFs because of the increasing need to offer end-of-life care related to chronic conditions. However, it is unknown if the workforce employed by LTACFs are adequately equipped to implement and deliver palliative care (Philips et al., 2006). Jeong, Higgins and McMillan (2010) stated that LTACFs were considered to be the place where end-of-life care would occur for older adults who were frail and had "chronic progressive illnesses" (p. 391) and, in Philips et al's. (2006) study, the participants questioned the ability of the GP to carry out specialist palliative care. Comondore et al. (2009) found that the quality of care delivered by LTACFs was identified as a long-standing concern.

## **2.3. Workload challenges and lack of recognition**

In LTACFs, the staff who provide direct care to the residents usually consists of Health Care Assistants (HCAs<sup>3</sup>), Enrolled Nurses (ENs<sup>4</sup>), and RNs. The HCAs are usually the majority in numbers within the staff ratio and therefore the HCAs provide the most direct care to the residents. Following from the HCAs, there may be 1-2 ENs and one RN per duty. During a morning shift in a LTACF, there may be other RNs on duty, for example the Clinical Nurse Manager (CNM) or other RNs who are overseeing other wings of the facility. However, during the afternoon and night shifts there is usually only one RN on duty for the whole facility with the rest of the care staff consisting of HCAs. Depending on the number of beds the facility has, the workload is usually based on a staff-to-resident ratio that consists of one HCA to five or six residents.

In the study undertaken by De Bellis (2010), many issues facing the aged care environment were found, ranging from an environment where care was time pressured, the role of the RN was covert or absent, to unsafe nursing practices placing both residents and RNs at risk. In her study, McKenzie-Green (2003) found that there were usually five residents

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<sup>2</sup> Residential Aged Care Facilities

<sup>3</sup> An HCA is an unregulated worker who is employed by LTACFs and provides direct care to residents.

<sup>4</sup> An EN is a nurse who delivers nursing care to residents but is under the direction and delegation of a RN or NP (NCNZ, n.d.b)

to one HCA, with an RN having up to 26 residents in their care on a morning shift. During an afternoon shift, the number of residents to the RN increased because the RN was also expected to oversee the outlying buildings that were a part of the LTACF. The number of staff available during the night shift was even less compared to the morning and afternoon shifts. McKenzie-Green (2003) further noted that, across the facilities, staffing levels were inconsistent with one facility, considered to be a high level care facility, having six staff in total (two RNs and four HCAs) caring for 35 residents. Inadequate staffing levels were found to contribute to poor care delivery in aged care, however, McKenzie-Green (2003) noted that the way care was delivered and the attitudes of the staff contributed to the quality of care delivered. Countering this attitude, McKenzie-Green (2003) also identified a resistant attitude (and in some cases refusal) of HCAs to provide care or to change their delivery of care to residents, even when instructed by the RN. Other findings in this study were staff not having enough time to complete the required workload tasks, supervise HCAs, spend time with family or residents, or provide care (McKenzie-Green, 2003).

In keeping with the complexity of care, the literature showed that in order to plan appropriate care required for the resident, more observation time was needed. This increased observation time has been highlighted with the increase of palliative care in LTACFs (Philips et al., 2006). The purpose of providing palliative care is to implement care that will control symptoms, provide comfort, maintain dignity and comfort, improve the quality of life, and understand the needs of the resident and the family (Philips et al., 2006). As indicated earlier, it has been questioned whether or not LTACFs have the capacity to care for dying people. Since HCAs are responsible for the providing the most direct care to the residents, Touhy (1997) contended that by delegating the basic cares of our residents to unskilled staff the residents are being deprived of appropriate care based on the skill required related to complexity of condition, in addition to the loss of opportunity to form a RN-to-resident relationship. The HCAs will have a relationship with the resident more easily because they provide the most direct care to the resident.

In addition to skill mix affecting care, quality of care has been linked to the working conditions of employees. Kaine and Ravenswood (2013) identified poor working conditions in aged care included stress among staff, lack of time to complete care and tasks, and the intensity of the workload. Kaine and Ravenswood (2013) recognised that, in order to provide quality care to residents, there was a need for the employment of skilled workers and a need to improve working conditions in LTACFs. With the current constraints on funding for the aged care sector, Kaine and Ravenswood (2013) note that in order to overcome the need for more

workers, organisations are increasing the workload of the existing work force by increasing the number of residents per staff member per shift. Not only is the workload increasing but so too is the intensification of the work increasing because tasks, considered complex, are delegated to workers who lack the appropriate skills. Whilst these activities are designed for cost efficiency, Kaine and Ravenswood (2013) noted that, by passing on complex tasks to unskilled workers, the cost to the aged care sector was actually increased because of the increased risk to safety for both residents and staff. Despite the cost efficiencies in place, Austin (2000, as cited in McKenzie-Green, 2003) noted that,

many providers of aged care have been operating under considerable financial constraints in recent times. Managing tensions between addressing need, maintaining quality services, workforce training, retention and skills development, within limited resources have all been major challenges within the age care sector and the health sector as a whole, over the last ten years. (p. 9)

Furthermore, Philips et al. (2006) found that financial constraints made it difficult for RNs to meet residents' needs. Related to financial constraints are staffing issues, in Australia, there is concern that the care needs of the older population are not going to be adequately addressed because of factors related to quality of care and the inability to recruit, and also retain, nursing staff (Richardson & Martin, 2004). With staff turnover acknowledged as an issue, Richardson and Martin (2004) showed that, each year, an employer needs to replace one in five RNs and one quarter of the HCAs employed in aged care. The ongoing issues related to staff shortages and the varied skill mix of staff made it difficult to provide care (Philips et al., 2006). As well as the fact that unskilled staff was considered to have increased the workload of the RNs (Stull & Vernon, 1986). Kaine and Ravenswood (2013) emphasise that there is minimal legislation in NZ regarding the workload of staff in aged care or mandatory training for HCAs which also impacts on how staff are recruited.

A survey undertaken by the New Zealand Nurses Organisation (NZNO) in 2005 showed that although the majority of LTACFs that provided hospital-level care met the requirements of having at least one RN on duty at all times, it was uncommon for there to be more than one RN even in larger complexes (Networkers, 2005). It was also found that the total number of RN staffing hours fell well below even the minimum indicator set by the MoH. Whilst HCA hours were closer in meeting the indicator levels they were deemed to still be at least short of 10 full time equivalent (FTE<sup>5</sup>) HCAs per week (Networkers, 2005). This study

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<sup>5</sup> FTE refers to a group of employees who are counted as full-time equivalents but as individuals they work part time (Employer shared responsibility provision: Key definitions, n.d.)

also found that RNs were coming in on their days off to complete work such as paperwork. They were also required to undertake tasks such as doing the cleaning and the laundry in addition to their nursing workload (Networkers, 2005).

The impact that short staffing and low numbers of available RNs on duty at a given time has have far reaching consequences when considering the mandatory requirements imposed upon aged care facilities, and the work intensity creating reduced skill and workforce numbers for the same amount of residents. The limited number of available RNs on a duty has a significant impact to the future of aged care nursing in as much as the practicum experiences that undergraduate nursing students are exposed to in this setting might influence their desire to work in an LTACF once they have completed their study (Grealish, Bail & Ranse, 2010). One of the main reasons for students' ill perception of aged care is that they are unable to work alongside the RN due to the limited time and number of RNs available on the shift (Grealish et al., 2010). Given the increasing need of skilled RNs in aged care with the rise in the older adult population, it is concerning that student nurses are not expressing a desire to work in aged care (Grealish et al., 2010). With the increasing difficulties of providing care to a vulnerable group in an environment requires a high degree of accountability, staffing shortages are intensified because RNs move towards work environments that appear more appealing and better paid (McKenzie-Green, 2003). McKenzie-Green (2003) showed that if there were staffing shortages, the care delivered became more routine care. The ill perception of aged care is not isolated to student nurses. Although McKenzie-Green (2003) recognised care in aged care as complex and multifaceted, Touhy (1997) found that the level of skills and knowledge actually required when providing what is considered just basic care was often unacknowledged. As stated by Touhy (1997), "and yet, assistance with meeting basic needs for care is the skill nursing brings to people. It is our *raison d'etre*, the essence of our profession" (p. 5).

Philips et al. (2006) highlighted how participants acknowledged the perception that aged care RNs have a lower status when compared to their peers in other areas of nursing. The difference in salary between the aged care RN and RNs in other areas of nursing, in that the aged care RN was paid significantly less than an RN in a different setting, was an example of the low status associated with aged care (Philips et al., 2006). Participants felt that their professional judgements were not considered by families or other health care professionals. Even though the RNs acknowledged that a specific set of skills was required to care for older adults, the participants were of the opinion that their practice was not seen as a specialty (Philips et al., 2006). Touhy (1997) commented that the skills of the aged care nurse needed

to be acknowledged as a skill set that was important. In combination with this viewpoint has been the association of aged care nursing with needing limited skills and being a place where skills are lost (Kane et al., 1989).

Despite the lack of acknowledgement for nurses working in aged care, Richardson and Martin (2004) found that the majority of RNs and HCAs believed they had the appropriate skills to complete their work. However, Langer et al. (1991) and Carryer et al. (2010) found that the lack of RNs with the appropriate skills and knowledge to manage complex conditions as well as the short staffing issues were factors that resulted in resident admission to hospital. The RNs commented that available educational opportunities were also insufficient for them to acquire the knowledge and skills appropriate to the care required by residents with such complex needs (Carryer et al., 2010). This factor was further compounded by a shortage of GPs to support the decision making related to the care provision in the aged care facilities.

#### **2.4. Communication challenges**

Communication in the health care setting can be challenging, particularly where care crosses numerous health care organisations such as that found in the aged care setting where care is a collaboration between the residential facility, the GP and often the acute hospital setting. Clarin (2007) commented that poor communication between health care professional's impacted on the care that patients received and could also be a barrier to effective collaboration. Coleman (2003) recognised that people who were considered to have continuous complex care needs often needed to be seen by a number of health professionals. Those who reside in LTACFs are already dependent on others to provide the care they need, and as it was mentioned earlier, older adults who are admitted to hospital from a LTACF are also at risk of further complications. Therefore, the risk of vulnerability, which was already high in this population of people, was further increased by a lack of or poor communication within the multidisciplinary team (MDT<sup>6</sup>). This study found that an older adult with one or more co-morbidities was likely to see eight different physicians on average in one year. Amongst other adverse effects that poor communication can cause, it was found that the most significant adverse effect resulting from poor communication was medication errors.

Philips et al. (2006) found that there was difficulty of communication between the HCAs and RNs. Given the amount of time HCAs spent with the resident, they were in a position to notice changes in the resident. However, the limited skill and assessment levels of

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<sup>6</sup> An MDT consists of professionals from different health care backgrounds that contribute towards treatment plans for a patient (Northern Territory Government, 2015). Each member of the MDT will have knowledge, skills, and expertise that is considered specialist (Northern Territory Government, 2015).

the HCA often means that the HCA is unable to communicate effectively to the nurse what their concerns are. In turn, the RNs needed to use simplistic language to communicate to HCAs how to carry out care for the residents. This use of simplistic language has impacted on the RNs' ability to communicate effectively with the GP because the RNs were no longer able to describe the clinical event/condition using the appropriate clinical language (Philips et al., 2006). Philips et al. (2006) found that poor communication was a barrier to the RNs having the appropriate clinical plan to support the care required for residents and this not only challenged nursing, but also frustrated the GPs. This scenario can well lead to the readmission of the resident to an acute care facility.

## **2.5. The impact of early discharges and admissions to the ED and hospital**

It is thought that older adults from LTACFs are frequent users of the ED services. Often, the appropriateness of admission to the ED is questioned. It is known that admitting older adults to hospital can have adverse effects on them and increased risk of medical complications. Zeitz et al. (2010) found that hospital settings were seen as "hostile places for older people" (p. 44).

The impact that early discharges from hospital would have LTACFs has been a theme in the literature. The impact of the decreased average length of stay in the hospital setting on LTACFs has been significant, with Langer et al's. (1991) study showing that the number of patients being discharged to LTACFs had increased to 60% from 38%, highlighting the increasing burden being placed on LTACFs to provide a far greater complexity in care provision. This finding was recognised by Carryer et al. (2010), who noted the increased pressure placed on LTACFs to accept the care of more complex presentations because the health care system was becoming overwhelmed by this population.

A study in the United States of America showed that up to 47% of older adults from LTACFs presented to the ED (Finn et al., 2006). It is unknown over what period of time these admissions occurred. The objective of Finn et al's. (2006) study was to determine the appropriateness of presentations of the older adult population from LTACFs to the ED in Australia over a period of 6 months (Finn et al., 2006). Of the 541 residents who were admitted to the ED, only 71 were considered inappropriate, with 326 being admitted to hospital and 276 surviving to be discharged. The main reasons for the ED presentation were falls, pneumonia, and musculoskeletal issues (Finn et al., 2006). Langer et al. (1991) found that patients who were discharged to LTACFs and who required more complex treatment were more likely to be readmitted to hospital. Furthermore, if the LTACFs had the appropriate

resources and staff with the required skills to provide this care, a significant number of readmissions to hospital could have been avoided (Langer et al., 1991). This finding has been supported by other studies which found that improving primary care was one of the factors that might reduce the number of elderly being admitted to hospital (Arendts & Howard, 2010).

Linked with the stress of caring for the older adult is the collaboration between acute services and aged care facilities. Jones, Dwyer, White and Firman (1997) undertook a study that aimed to examine the process LTACFs used when transferring residents to the ED and the outcome of these transfers for the residents. From the 709 residents surveyed, a total of 1,012 transfers to the ED were made. Sixteen residents died in the ED, 319 were admitted to hospital, five were transferred to another hospital for admission, and 369 returned to the LTACF (Jones et al., 1997). Although 77% of admissions to the ED were considered to be appropriate, in 12% of the cases the RNs from the LTACFs were unable to contact the GP prior to the resident being transferred to the ED. In 68% of ED transfers, the GPs only contact with the LTACF was via telephone and the average wait time for the return call to the LTACF was 5 hours (Jones et al., 1997). The authors of this study considered LTACFs made recurrent transfers of their residents to the ED because they were unable to provide the appropriate care needed for older residents with complex needs (Jones et al., 1997). It could be argued that because of work intensification, the nursing staff in the LTACFs are sending residents to hospital sooner, because they are able to care for the residents appropriately, based on time and resource constraints. This in itself presents the next theme; and that is moral distress in the aged care workforce.

## **2.6. RNs' moral distress and unhappiness in their jobs**

In nursing, moral distress is one of the key reasons nurses not only leave their employment setting but also the reason nurses leave the nursing profession as a whole (American Association of Critical-Care Nurses, 2015). Moral distress occurs when the nurse is unable to provide the care they consider their patient to need which results in the nurse "feeling a loss of integrity and dissatisfaction with their work environment" (American Association of Critical-Care Nurses, 2015, para. 1). A study conducted by Richardson and Martin (2004) showed that RNs were more likely to be dissatisfied or neutral about their work compared with other health professionals in aged care such as the HCAs and the Allied Health Team. This finding was supported by McKenzie-Green (2003) whose study showed that RNs working in aged care were unhappy in their jobs. Kaine and Ravenswood (2013) found that the lack of recognition and poor pay were related to job dissatisfaction.

The type of work environment influences the attraction and retention of staff as noted by Richardson and Martin (2004) who found that the majority of the workforce did not believe they had enough time to spend with the residents. Furthermore, this study found that the majority of RNs estimated that less than one third of their time was spent providing direct patient care. There was conflict for participants with providing appropriate care within the given timeframe, which resulted in staff working harder (Richardson & Martin, 2004). It was shown that the available time given to RNs did not allow them to complete all their expected tasks. The majority of RNs felt they were under pressure to work harder, which Richardson and Martin (2004) linked to decreased work satisfaction as well as to attraction and retention of staff. Furthermore, Richardson and Martin (2004) noted that this pressure to work harder also reduced the capacity to increase staff workload. The difficulty of trying to provide appropriate care to residents whilst battling against restraints was also noted by Philips et al. (2006).

In the study undertaken by McKenzie-Green (2003), it was found the HCAs were hiding from care, or sitting together talking, or taking their breaks as soon as cares were complete leaving the RN alone on the floor. One participant in this study commented on the struggle for the RN in wasting time looking for HCAs or needing to spend their breaks at the RN station because everyone else had left to take their breaks (McKenzie-Green, 2003). The participants in this study stated that the majority of complaints they made to management regarding HCAs were related to "inadequate care of residents. This inadequate care ranged from verbal abuse to inadequate physical care" (McKenzie-Green, 2003, p. 165). McKenzie-Green (2003, p. 168) also noted the "escalating stress" related to the RNs recognising they were unable to deliver the required care in the environmental constraints. This distress was also increased when families and residents complained about the way the resident was being treated. McKenzie-Green (2003) identified the quality of care as being directly related to the number of staff available on the shift and the way the organisation's system was structured.

Carryer et al. (2010) explored the experiences of RNs who worked in aged care in NZ and found that the RNs were isolated, their confidence was low, and the chances for new graduate RNs to enter the aged care workforce were minimal. Factors were identified by the RNs that contributed to their struggle to administer quality care to the residents and these included the increasing acuity of residents, limited opportunities to improve their knowledge and skills, and the lack of GP availability resulting in delayed interventions (Carryer et al., 2010). In addition to these issues, Carryer et al. (2013) identified the use of HCAs created stress on the RNs because the RNs were accountable for the HCA's practice. One RN stated

it was difficult to ensure that HCA care was appropriate or safe when they were not involved in the employment or discipline processes for these caregivers. The same RN respondent also cited limited opportunities and resources for the RNs to provide the HCAs with training (Carryer et al., 2010). The authors noted that "consequently the nurses found themselves accountable for care provided by people they were reluctant to trust" (Carryer et al., 2010, p. 14). Another issue by Philips et al. (2006) was related to the difficulty of advocacy where RNs found it difficult to advocate for their patients, particularly when the GP's and family's wishes differed from that the resident's wishes. Adding to moral distress, is the isolated role of the RN in aged care facilities.

The workforce in the LTACFs often relies upon one RN across a large number of residents managing and co-ordinating care. In this position, RNs have little support in terms of difficult decision making where care changes are involved. Philips et al. (2006) found that the RN often worked in isolation and lacked access to other health professionals which resulted in care that lacked a collaborative MDT approach. Furthermore, Mckenzie-Green (2003) found that RNs worked in isolation, with one RN in a facility responsible for a high number of staff and residents. Furthermore, Philips et al. (2006) found that participants in their study did not feel that the care provided to residents was multidisciplinary or collaborative.

## **2.7. Shortage of GPs and related issues**

Philips et al. (2006) noted the shortage of GPs in their study, which also found that the additional workload placed on the existing GPs created a situation where RNs were reluctant to place additional burden on GPs in case it caused the GPs to withdraw their services from the LTACFs. In keeping with the ongoing GP shortage, Kane et al. (1989) noted the lack of timely interventions which has been an issue since the late 1980s. In Philips et al's. (2006) study, the participants were concerned about the length of time the GPs took to see the residents, some commenting the GP could take weeks before they came to review a resident or only came at the end of the day to see urgent residents. Some participants expressed the view that this was too late and perceived this delayed review by the GP as a disinterest in aged care (Philips et al., 2006).

Carryer et al. (2010) identified that the RNs' perceived the GPs to have little interest in aged care because of the GPs' lack of prompt review and delayed return of the RNs' phone call, and because the GPs would often leave the review of the resident until the end of the day which made it difficult at times to access other services, such as pharmacies, because these were often closed when the GP arrived. The potential consequences of a late review were

scripts not being dispensed until the next day and residents being admitted to hospital for simple interventions that had not been addressed at the LTACF (Carryer et al., 2010). Adding to the GPs' inability to promptly attend to aged care residents has been the decline in the number of self-employed GPs to more GPs choosing to work flexible and part time hours. These changes have resulted in self-employed GPs working longer hours and the existing GPs having less time to review any unexpected patients (Carryer et al., 2010).

The reduced availability of GPs and the limited ability of LTACFs to provide appropriate care to the older adult population with complex needs, have been reoccurring themes throughout the above literature. This fact is supported by Peri, Boyd, Foster and Stillwell (2013), who stated that a number of GPs have decreased their services provided to LTACFs because they are struggling to provide care to both the general population and these facilities. This finding supports a study undertaken in Ontario, Canada where the integration of NPs into LTACFs occurred because of the lack of GPs and the lack of resources "to manage increasing numbers of residents with complicated health problems" (Stolee, Hillier, Esbaugh, Griffiths & Borrie, 2006, p. 28). However, despite the acknowledged benefit of the NP role in these instances, the development of the NP role was noted to be reliant upon GPs who are known to play a fundamental role in the provision of care and who provides that care, in most developed countries (Mackay, 2003).

In keeping with this trend, Taylor et al. (2012) noted that the length of consultation time given by a GP in an LTACF has decreased in spite of residents being more complex. Other possible reasons identified by the researchers for increased shorter consultation times were lack of skilled staff and the facility's inability to manage minor medical issues, which placed a greater demand on the GP, creating a reason to provide shorter consultations (Taylor et al., 2012).

## **2.8. Families' viewpoints**

The struggle families often face when placing a loved one in an LTACF is that they perceive that their loved one is treated the same as everyone else and that their differences in needs of care are not considered (Bauer & Nay, 2003). However, Bauer and Hay (2003) say that families tend to be reluctant to complain because of the perceived power the staff have leading to concerns over how care delivery given to their family member will alter as a result of differences between family and staff.

A study undertaken by Wetle, Shield, Teno, Miller and Welch (2005) examined the experiences of families regarding end-of-life care in LTACFs in the United States of America.

Results showed that some participants seldom saw the GP whilst others stated that the quality of interaction with the GP was unsatisfactory. Despite this lack of GP support, participants did not favour the role of the NP because they felt they were 'stepping in' for the GP (Wetle et al., 2005). This is in spite of participants stating that the changing conditions of the residents were often missed by LTACF staff, which resulted in "Missed Opportunities for Advanced Care Planning and Palliative Intervention" (Wetle et al., 2005, p. 645). This missed care resulted in unnecessary transfers and treatments which added to the suffering of the residents concerned. The participants stated that the information they received from the RNs was insufficient and that the RNs failed to adequately meet the emotional needs of the residents and families (Wetle et al., 2005). Other findings showed that the LTACFs were often understaffed, which meant basic needs of residents, such as toileting, were not met; RNs provided 'task focused' rather than 'person-centred' care; and referrals to other organisations such as hospice did not occur, or were made too late (Wetle et al., 2005).

Countering concerns for the NP role, was a study undertaken by Ploeg et al. (2013) which examined perceptions of family members and residents regarding the NP role in LTACFs in the United States of America which identified two themes. These two themes were, that the families and residents felt that the care provided by the NP was person-centred, and the care provided by the NP was of a higher standard of quality (Ploeg et al., 2013). In this study, the participants stated that the NP included them in the decision-making process and allowing them to participate in the care. The timeliness of care from the NP was perceived positively by the participants as they stated it prevented unnecessary admissions to hospital (Ploeg et al., 2013). This view supports the need to examine the nursing workforce in aged care that will address the lack of appropriate skill mix, as well as the shortage of GP support.

## **2.9. Regulatory requirements**

As noted in the previous section, the regulatory requirements imposed on staff working in LTACFs made it difficult for them to meet the needs of their residents, and because of the reduced time in which to provide care, in addition to the increase in the paperwork which is found to be "repetitive and arduous" (Philips et al., 2006, p. 420). In this constrained environment RNs were too afraid to ask the residents how they were doing in case they were "trapped" into staying with the resident longer than they were able to within the time allocations (Philips et al., 2006, p. 420). Stull and Vernon (1986) found that the paperwork was a factor that was considered to have increased the workload of the staff. Although the work in aged care is complex, McKenzie-Green (2003) commented that the work is delivered

in an environment that is constrained by funding issues, staffing shortages, inadequate skill mix, and rising resident acuity, and that above all these conditions are exacerbated by the required level of accountability and Government auditing. Despite the literature showing the increasing demands placed on RNs and GPs to meet regulatory requirements, De Bellis (2010) showed that the residents' care plans were out of date and that if anybody did choose to follow these out-of-date care plans, they may be putting themselves and the residents at risk.

## **2.10. Introducing the NP role**

In NZ, the NP role was introduced in 2001 (College of Nurses Aotearoa NZ, 2010) with the aim of reducing the workload of the GP and of providing New Zealanders with alternative access to health care (MoH, 2009). The NP is an expert nurse who provides advanced knowledge and skills in a particular area (NCNZ, n.d.a). As per the NCNZ (n.d.a), the NP scope of practice is

Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people's health needs. They provide a wide range of assessment and treatment interventions, including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests, and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse practitioners prescribe medicines within their specific area of practice. Nurse practitioners also demonstrate leadership as consultants, educators, managers and researchers, and actively participate in professional activities, and in local and national policy development. (para. 1)

Historically, the role of the NP was first introduced to meet a demand for care that was unable to be met by GPs in the United States of America in 1965. In Canada, the NP role had been in existence for over 40 years (Sangster-Gormley, Martin-Misner, Downe-Wamboldt & Dicenso, 2010). What created this gap in care was the movement of GPs out of primary care and health care being made more available by the medical insurance companies, which placed a greater demand on primary care services (O'Brien, 2003). The decreased GP numbers and the increased available health care cover resulted in many hard-to-reach areas, such as rural communities, deficient in health care. This gap in care could be filled by a RN

with an expanded role, and "society's demand for primary care services and nursing's potential to meet the need were the reasons for the development of nurse practitioners; the physician shortage merely provided the opportunity" (O'Brien, 2003, p. 2302).

The NP role has been met with considerable resistance since it was first developed, with much of the opposition coming from both the nursing and medical sectors. Nurses argued that the title was "ambiguous and misleading" and that nursing would no longer be practised by the NP, whilst doctors were concerned that the nurse would not be working under their direction and considered the NP role as "bad doctoring" (O'Brien, 2003, p. 2302). Due to both roles sharing similar role functions, there is an overlap which has resulted in issues. It has been shown that if doctors and NPs work collaboratively, there is an increase in positive patient outcomes. However, the NPs filled this gap in care and with the increased need to have health care that was both cost effective and accessible, the NPs gained success in numbers and autonomy (O'Brien, 2003).

One of the key research projects undertaken in NZ evaluated the NP role in aged care (Peri et al., 2013). With the limited number of GPs available in Horowhenua, and the increased use of locum GPs, it was difficult for the GPs to meet the needs of the LTACFs as well. Trialling a new primary health care model, the NP was to share their time between the three LTACFs and the Primary Health Organisation (PHO), as well as respond to the community's needs (Peri et al., 2013). To evaluate the role of the NP, the three LTACFs that had access to the NP were compared against three LTACFs that did not have access to the NP.

The results from this study showed that the NP had multifactorial benefits that included more timely interventions, holistic and person-centred health care delivery, reduced polypharmacy, reduced ED and acute hospital admissions, improved collaborative practice within the MDT; also the LTACF staff felt an improvement in their abilities and confidence (Peri et al., 2013). It was also found that the role of the NP was supported in LTACF by the GPs, RNs, residents, and family members.

### **2.11. Barriers to the NP role**

There have been many barriers to the NP role, such as funding issues, blurred boundaries and confusions of roles, and "opposition from the medical profession and inconsistent education requirements" (Sangster-Gormley et al., 2010, p. 1179). A multitude of factors such as ongoing funding issues, lack of support for the NP role by GPs, lack of government legislation and funding for educational programmes, and the continuous

knowledge deficit around the NP role resulted in the closure of many NP educational programmes in Canada (Sangster-Gormley et al., 2010). From the review of literature, Sangster-Gormley et al. (2010) found that barriers to the implementation of the NP role in Canada remained. These barriers included no standard job description being available, restricted role domains caused by a lack of legislation and regulation, insufficient administrative support for the NP role, continuing funding and workload issues, culture of the organisation, expectations that were conflicting, lack of long-term resource planning of the NP role, and the issue regarding NP autonomy (Sangster-Gormley et al., 2010). Donald et al. (2009) found that the majority of NPs and GPs acknowledged that collaboration was occurring barriers, to the NP role continued, which impacted on collaboration and quality of the residents' care. These barriers included patch protection and confusion of roles.

In the New Zealand research by Alexander (2008), reluctance remained over the NP carrying out what were perceived to be medical tasks such as prescribing, initiating treatment, and undertaking physical assessments. The GPs believed that NPs lacked the medical knowledge to carry out these tasks and therefore that the NPs might endanger public safety (Alexander, 2008). Funding of the NP role and medico-legal issues were also found to be factors hindering NP role development. Alexander (2008) stated that the ongoing concern around the medico-legal issues showed that there continued to be a misunderstanding around the NP role. Alexander (2008) further explains that:

the continuing ethnocentric belief that once NPs gain the 'prescription pad' they may become unsafe. The GPs continue to be unsure about how safe and competent NPs are, regardless of evidence to show NPs make very few significant prescriptive errors. Given this continued uncertainty NPs are often only accepted after have 'proven' their competence. (p. 49)

This study also showed that RNs and GPs perceived the other group to have issues accepting the NP role. However, it was shown that both groups agreed that the GPs would have greater difficulty accepting the NP role (Alexander, 2008).

The lack of doctor knowledge about the scope of the NP was found to be a barrier to the NP role in Clarin's (2007) study. The overlapping nature of the roles was shown to make it difficult for team members to "claim their patient management role" (Clarin, 2007, p. 540). Other barriers to the NP role were doctors' poor attitudes towards the NP, poor communication, doctors perceiving collaboration to mean that the NP practised under their

direction, lack of respect, and the reluctance of patients and family to accept the NP role (Clarín, 2007).

Mackay (2003) surveyed GPs in Northland, NZ focusing on the GPs' knowledge of the NP role, GPs' perceptions of the NPs role functions, and any potential problems perceived by GPs in using an NP. The study showed an overall favourable view for the NP role by GPs, and concluded that the NP could contribute to improved community care. However, the role functions of the NP regarding requesting laboratory tests, completing physical examinations, and prescribing remained a concern for the GPs. Rather than supporting the NP in these role functions, GPs were instead inclined to support the role functions that were customarily part of the nursing role (Mackay, 2003). The biggest cause for concern by the GPs was funding for the NP role and role confusion. Although Mackay's (2003) study showed that the GPs' perceptions and understanding of the NP role had increased from previous studies undertaken, there still remained areas, such as funding, prescribing, and issues of accountability where further clarification was required.

These issues have also been raised in the United Kingdom. Focus group interviews were used to research GP perceptions of NPs in primary care, what they perceived the barriers to be for these nurses in entering primary care, and lastly, how these barriers could be overcome (Wilson, Pearson & Hassey, 2002). The sample size consisted of 25 GPs from four different practices. Of the four practices, one practice did not intend employing an NP, one practice had employed an NP for two years, one practice was considering employing an NP, and one practice had an NP in training (Wilson et al., 2002).

The results showed that the GPs were concerned that the NPs would be given the easier cases and that they would be left with the more complicated cases, thereby providing no relief from stress levels, but rather adding to them. Furthermore, those GPs who were working with NPs found that although there had been a change in the GPs' workload, overall the GPs' workload had not decreased (Wilson et al., 2002). Those GPs who had not worked with NPs were concerned that they would begin to lose some skills and others were concerned that this would lead to a decrease in their confidence. Other aspects of concern for the GPs centred on threats to the GP's financial position and their job security. A second theme that emerged was the GPs' concern regarding the ability of the NP to assess and diagnose patients as "only doctors had the necessary training, skills and intellect to adequately assess patients and diagnose disease" (Wilson et al., 2002, p. 643). The third theme highlighted constraints around the NP role. The constraints discussed were the NPs' inability to prescribe (the GPs saw this as a barrier to patients wanting to see the NP) and the

funding to employ an NP. The GPs stated that NPs required higher pay than general practice RNs, which would affect the staff budget (Wilson et al., 2002). The last theme to emerge focused on the more traditional roles of the GP and RN, and the GPs stated that patients would rather see a GP, particularly older people, because traditionally RNs were seen to follow doctor's orders rather than practise independently (Wilson et al., 2002).

Contradicting the claims that NPs did not reduce the workload, Wilson et al. (2002) noted that where Practice Nurses had been trained to undertake specific clinical care, positive outcomes regarding reduced GP workload, reduced cost, and improved patient satisfaction were seen (Wilson et al., 2002). In recent study by Clark et al. (2014), the role of the NP in older care was shown to improve outcomes, enhance access to care, and provide care in the home or in the place of residence, further relieving the burden on GP practices.

Wilson et al's. (2002) study demonstrated that RNs were capable of undertaking extended roles but their study also demonstrated that there was "a reluctance to believe such evidence without also developing a personal confidence in the nurse in question" (Wilson et al., 2002, p. 644). The need to develop confidence in the RN first may be due to vagrancies around the NP role regarding who would take legal responsibility should the NP cause accidental harm to a patient. As indicated by Mackay (2003), the concerns raised by the GPs in the above study had the potential to hinder the development of the NP role into primary practice (Wilson et al., 2002).

A study undertaken by Lowe, Plummer and Boyd (2013) explored the perceptions of NPs, Nurse Policymakers, and Nurse Managers regarding the incorporation of the NP role into health care settings in Australia. The three aspects they surveyed were sustainability of the role, how supported NPs were in the participants' organisations, and if NPs were held in positive regard in the participants' organisations (Lowe et al., 2013). The aim of the authors was to determine what approaches could ensure the continuation of the NP role. From the data received, the results showed that 92 participants agreed that their organisations supported the NP role and that 116 participants agreed that their organisations had a positive regard for the NP role. However, the researchers stated that the data received regarding "there is good understanding of the NP role in my organisation" showed that further effort needed to be undertaken with regards to "define the NP role and their function in health care settings" (Lowe et al., 2013, p. 31). Furthermore, the researchers stated that the continued vagaries regarding the NP role and their contribution to health care potentially impacted on the input the NPs could have in health care delivery as well as on the progression of their role (Lowe et al., 2013). Although the benefits of the NP role for health care delivery are well

documented in the literature, Lowe et al.'s (2013) study showed that funding and medical support remained key factors for role implementation and integration. Nurse Managers and Nurse Policymakers stated that there were benefits to those employing an NP. However, Lowe et al. (2013) found that several participants disagreed with the statement that NPs were well supported.

## **2.12. The NP role now**

The question has to be asked as to whether there is any change in perception of the NP role by other health care professionals. Sangster-Gormley et al.'s (2010) study found that the NP role was available across Canada but was newer in some provinces with confusion around the NP role prevailing. This is in spite of earlier studies that showed that NPs improved access to primary care and that the care they delivered was just as a safe (Sangster-Gormley et al., 2010). The role of the NP has been evolved to meet the demands of workforce shortages and health care services (Lowe et al., 2013) and it has been shown the care provided by NPs was just as safe as a GPs, and in some cases, patients have reported higher satisfaction with NP care (Horrocks, Anderson & Salisbury, 2002). As stated by Clark et al. (2014), the NP role has been used to improve the timeliness of interventions as well as access to health care, and studies have shown that the care provided by NPs was safe and of high quality. Although the study found no differences in patient outcomes between NPs and GPs, it has been shown that NPs spent longer with the patients and that patients reported higher satisfaction with the nurse-led care (Clark et al., 2014).

Recognising the need to address the growing older adult populations' demands on health care, the Australian Government set about supporting the NP role in aged care with three goals: "(a) identify effective, economically viable and sustainable models of practice; (b) facilitate the growth of the aged care nurse practitioner workforce; and (c) improve access to primary health care for clients of residential and community aged care service" (Clark et al., 2014, p. 1594). Successful models of NP care in aged care focused on factors such as providing care that was the right care, at the right place, at the right time. The right care focused on being culturally appropriate care and not being reactive to illness but promoting wellness instead (Clark et al., 2014). Furthermore, the right care included assessing for the prevention of illness onset and preventing/reducing deterioration. The right place focused on providing care to the elderly, either in their homes or in LTACFs, and avoiding places of care such as the hospital. The right time focused on implementing timely care, having NPs available after hours, and implementing preventative care (Clark et al., 2014). Alexander (2008) found that 92% of GPs showed an overall favourability towards the NP role in primary

care. With regards to collaborative prescribing and working in collaboration, the GPs appeared to be favourable. GPs who had previous experience of working with NPs in other countries were more favourable to the NP role (Alexander, 2008).

### **2.13. Benefits of the NP role**

It was mentioned earlier that the NPs inability to prescribe was considered a barrier by the GPs for the NP role in that patients would opt to see a GP (Wilson et al., 2002). It should be noted that, at the time Wilson et al's. (2002) study was undertaken, the United Kingdom Central Council for Nurses, Midwives, and Health Visitors had reviewed nursing roles, and at this time, had chosen not to recognise the NP role, which the authors determined would have impacted on the development of the NP role (Wilson et al., 2002). In NZ, the NP is registered to practise as an independent practitioner, including having the rights of referral and admission to hospital (NCNZ, n.d.a), which would, in effect, reduce the workload of the GP in specific areas of practice, such as visitations in the aged care facilities.

As well as working closely with GPs, NPs also work closely with RNs. Gooden and Jackson (2004) undertook a study in Southern Illinois to survey RNs' attitudes towards NPs. The overall results showed that the majority of RNs perceived that the NPs provided care that was of a high quality and that, generally, their attitudes were positive towards the NP role (Gooden & Jackson, 2004).

A study undertaken in the Australian Capital Territory examined the potential role of an aged care NP (Arbon et al., 2008). The results of this study showed that the main role of the aged care NP would be to manage care issues of clients moving between care settings (Arbon et al., 2008). Arbon et al's. (2008) study also showed that the NP role could contribute significantly to clinical leadership in LTACF with regards to two aspects: administering nursing care that is of an expert level and being able to contribute to the development of others. These aspects were more recently supported by Clark et al. (2014) in which several NP projects were implemented across Australia, all providing examples of the adaptability of the NP role to the collaborative requirements that existed across locations, GP services, acute services and aged care facilities. As Arbon et al. (2008) also stated, NPs could improve residents' access of care through earlier assessments and interventions and could improve teamwork and communication within the MDT. The theme identified in this study that was consistent with other literature was the contribution of NPs working in LTACFs contributed improved outcomes of residents in LTACF.

Bail et al. (2009) undertook a study that focused on student NPs who provided care in LTACFs, acute hospital areas, and in the community over a 12-month period. The results of this study showed that the student NPs in LTACFs contributed to more continuous care of residents and that the student NPs had the potential to close the gaps in terms of both care provided across the different venues and within the MDT through communication and greater ability to collaborate (Bail et al., 2009). Ploeg et al's. (2013) study supported the use of NPs in LTACFs because the expert skills and knowledge of NPs could be beneficial to residents and family members with regards to making informed health care decisions and improving the care experience (Ploeg et al., 2013). Improved timeliness of care and delivering person-centred care identified by Ploeg and colleagues were consistent with the study undertaken by Peri et al. (2013). As can be seen in Peri et al's. (2013) study, the NP made a difference to the care of residents residing in LTACFs, provided support to both RNs and GPs and reduced the rate of resident admissions to the hospital.

#### **2.14. Conclusion**

This literature review has identified a multitude of issues faced by both GPs and RNs working in LTACFs when providing care to residents in LTACFs amidst the challenge of then also introducing a new role, which although perceived to support GPs and RNs, also poses a threat to their roles. RNs working in LTACFs are considered to be isolated and to have limited access to education and skill development opportunities in the face of enforced work intensification and increased care demands placed upon them with the increasing acuity of residential older adults. Increased responsibility to manage this care with HCAs as support has further increased moral distress being exhibited by RNs. In the face of an already reduced professional confidence that this fosters, comes the threat of a largely unknown role of the NP.

From the literature, it is evident that there continue to be issues around the NP role particularly where the NP role overlaps with the role of the GP. The GPs identified the following concerns: threats to GPs' financial and job securities; certain role functions of the NP, such as, prescribing, ordering diagnostic tests, and undertaking physical assessments and diagnoses; and legal responsibilities. These concerns are valid, but it has been shown that with, further education, many of these concerns could be easily resolved. It has also been shown that those GPs who have had experience working with NPs do not share these concerns.

The literature supports the need to explore different ways of managing care, with the examination of the division labour within the aged care services. This supports the need for an

exploration of RN and GP perceptions of the NP role in NZ. Whilst Alexander (2008) identifies the issues facing this shift in health care roles, there is a need to reconfirm those findings and to explore the perceptions of those most affected again, in the light of the ongoing issues that remain in caring for the older adult. In the next chapter, the framework and methods for the study are discussed.

## CHAPTER 3

### Research framework and methods

#### 3.1. Research design

The purpose of this research was to explore the perceptions of RNs and GPs regarding NP-led care in LTACFs in NZ. This research is an in-depth descriptive exploratory study. Critical Social Theory (CST) was used to inform the research, as it allowed for the facilitation of real time research based on participants' views, using observation and interviewing as the principal methods of information gathering. It examines social conditions in order to uncover hidden meanings and structures (Wodak, 2001). Critical Social Theory allows "oppressive socio-political conditions influencing health and health care" (Browne, 2000, p. 35) in LTACFs to be identified. In this manner, researchers challenge assumptions, rather than identifying or describing them. In relation to health care, using CST, the researcher can analyse how social relationships support the welfare and health of individuals, with the main goal of improving social conditions through empowerment and self-determination (Leahy-Warren, 2014; Park & Rethmeyer, 2012). Cassel (1976, as cited in Leahy-Warren, 2014) showed that "strengthening social support could positively influence the health of humans" (p. 85). With respect to this research, CST permits the collection of participants' viewpoints on how they perceive and interpret the NP role within an LTACF setting. Critical social theory enables the researchers to identify issues in society and then, through critical analysis (Babbie, 1998), to recommend changes that address the issues emerging from the research (Cresswell, 2013). Critical social theory also allows further literature to be used to support or refute findings (Cresswell, 2013; van Dijk, 2004).

The role of the nursing and medical professionals in aged care facilities is to provide quality, safe, and person-centred care. Furthermore, it is known that "nurses working with families of course want to be helpful and reduce or alleviate suffering whenever possible" (Wright & Leahey, 2005, as cited in Gardner, 2008, p. 11). Perron, Fluet and Holmes (2005) argue that such a workforce is unable to have full control over the care they provide, because their work environment is driven by political, legislative, and financial systems; Peron et al. (2005) call these systems "bio-power" (p. 536). In this situation, tensions at the intersection of the care/organisation boundaries manifest in the language and actions displayed by the workers, in this case, RNs and GPs providing care to residents in LTACFs. CST enables the researcher to identify and explore the social issues inside the facilities, the factors that limit and enhance independent actions and decision making within this society, and the factors that

influence these interrelationships within and beyond the LTACF, in order to increase and improve access and quality of care to the residents. The research methods used in this research included a descriptive exploratory survey that then offered the participants an opportunity to proceed to interview.

### **3.2. Structuring the survey**

The questionnaire used in this research was modified from Alexander's (2008) survey. The survey used in Alexander's (2008) study was originally developed by Radke and Wright, (1975, as cited in Mackay, 2003). For the modified survey used in this research, see Appendix 2. This survey was chosen because it had been used in two previous studies and was therefore considered to be reliable and valid in its measurement. In order for quantitative data to be considered valid and rigorous, the instrument used must be able to measure what it was intended to measure and must be accurate in its measurement. An instrument that is used by multiple studies has stronger acceptance of validity (Schneider, Whitehaed, Elliot, LoBiondo-Wood & Haber, 2007). Furthermore, this survey was also chosen because it outlined the different role functions of the NP and using a Likert Scale asked participants to rate how they viewed these role functions which directly relates to this research.

### **3.3. Modifications made to Alexander's (2008) survey**

The survey used in this research was taken from Alexander's (2008) study. The survey used in Alexander's (2008) study was originally developed by Mackay (2003). However, adaptations to Mackay's survey were made by Alexander (2008). The focus of Alexander's (2008) study was to survey the perceptions of GPs and RN, who worked in the primary care setting, regarding the NP role. For the purposes of this research, further adaptations were made to Alexander's (2008) survey to accommodate common themes, such as lack of access to GPs, workload issues, increasing complexity of elderly, access to education, and the issues of paper work that were identified during the literature review process. Therefore, to determine if these remained issues in New Zealand, Alexander's survey was modified to allow additional questions focusing on these issues. These questions were also added because the researcher acknowledged that these issues raised in the literature might be factors that influence the RNs' and GPs' perceptions of the NP role in aged care. The modified survey was reviewed for clarity by a RN who worked outside the aged care workforce. The analysis, discussion, and reporting of results obtained from all data sets were reviewed for credibility, reliability, and validity by the researcher's supervisors.

Since the aim of this research was to determine the perspectives of both RNs and GPs regarding NP-led care in LTACFs, the researcher deemed it important to gather specific data regarding the workload and experience of the participants relating to this area of practice and, therefore, additional questions that focused on the demographics and workload of the participants were included. Furthermore, additional questions that were included focused on the professional development opportunities of the RN. Lastly, two questions were added regarding the Health and Disability Services (Safety) Act 2001<sup>7</sup> to determine if the participants understood the reasons for the implementation of this Act and if they thought that it actually improved resident care or added to their work load.

### **3.4. Methods chosen**

This research used the conventional mixed methods design of survey and interview. During the literature search, it was found that often RNs working in an LTACF and GPs had a poor response rate to surveys. It was anticipated that the return rate for this research might be low and therefore the purpose of the interviews was used, to give added in-depth richness to the data and to counteract the limitations a low response rate could have.

RNs for this survey were sought from the hospital wing of LTACF. This was done because this is where the highest acuity of residents live, and where it is most likely that complex care needs require more care and co-ordination. The survey was available to RNs and GPs nationally and therefore the survey participants were from various locations across NZ.

#### **The survey**

Two surveys were sent out in August 2014; one to RNs working in the hospital wing of LTACFs, and the other to GPs who supported the care in LTACFs. Both surveys collected qualitative and statistical data, including demographic data and questions designed to elicit information that closely aligned with previous studies undertaken, for the purpose of data comparison. All questions (excluding demographic data) afforded the participants with an opportunity to write free text comments. With the anticipation of a low response return rate, the use of free text comments enabled the researcher to undertake a descriptive analysis of the data which would provide a richer and more informative analysis. The advantage of a survey was that it allowed for a wider sample of participants to be surveyed and that the participants were able to complete the questionnaire in their own time and environment. The

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<sup>7</sup> It is acknowledged that there is an updated Health and Disability Services (Safety) Act 2008, but on the MoH website, reference is still made to the 2001 Act (MoH, 2013a).

disadvantage of this method was that it did not allow for an in-depth analysis of perspectives from each group. However, this disadvantage was reduced, by including the free text within the survey and by inviting the participants to proceed to an interview. Critical social theory supports this approach because it supports the exploration of the perceptions of participants that can then be analysed with policy and other media information available on the World Wide Web, relating to the subject under scrutiny. In this way objects (in this case the NP role in the LTACF setting) are critically examined against the realities described by the participants that both hinder and support their views of the NP role, influenced both consciously and unconsciously, by the social structure (LTACFs) they are located within.

A list of certified LTACFs was obtained from the MoH website. Through telephone contact with the MoH, it was determined that the service types used to identify a hospital-level LTACF were psychogeriatric, geriatric, and medical. A total of 406 LTACFs were identified as having a hospital-level wing. From this list, 12 Aged Care Providers, with a total of 152 LTACFs nationwide, were contacted. The inclusion criterion was that the RNs needed to work in a hospital-level care wing. The LTACFs were aware of this criterion prior to participating

The RN survey was offered as either an electronic response through the use of Survey Monkey™ or completing a paper based survey. This was done on the advice of other researchers who advised that nurses will not always use the electronic mode of survey. The method of giving the RNs an option to complete the survey online or via return post was chosen to help increase the response rate as from the literature reviewed, it was shown that traditionally RNs working in aged care have a predominantly poor response rate to research. The sample of RNs was gathered by telephoning multiple LTACFs. One LTACF offered to electronically mail a covering letter and survey to their other sites which resulted in some snowballing taking place. Thirty-four LTACFs were invited to participate in the survey, and 29 consented to participate. A total of 295 packs were posted to the different facilities. Each pack consisted of a covering letter explaining the research, a survey, and a pre-paid self-addressed return envelope.

Eight surveys from the RNs were returned via Survey Monkey™, and 67 surveys were returned via post. This gave a total of 75 surveys returned. A timeframe of 6 weeks was given to each LTACF to complete the survey, with a reminder e-mail being sent either to the facility's manager or clinical nurse manager at three weeks. From the 75 returned surveys, a total of 20 consented to an interview. From the 20 participants who consented to an interview, nine were contacted. Two participants declined to be interviewed. A total of seven participants were interviewed, reaching data saturation.

The sample of GPs was gathered by approaching two medical organisations, who consented to provide a short description of the research, with a link to the GP survey in Survey Monkey via their weekly electronic newsletter. One organisation had access to approximately 5,500 members, of whom 1,400 were GPs. The other organisation had access to 4,205 GPs, who were members of their organisation. From this sample, there were 25 responses to the GP survey. One response was discarded as it was completed by a Practice Nurse. Therefore, there were a total of 24 GPs who responded to the survey. Of the 24 responses, 13 consented to an interview. From the 13 participants who consented to an interview, nine were contacted. Two participants declined to be interviewed. A total of seven were interviewed, reaching data saturation. Initially, it was requested that the survey be posted in the weekly newsletter for a total of 3 weeks. After 3 weeks, the organisations were requested to advertise the research for a further 3 weeks. One organisation consented to extending the timeframe but stated that, regrettably, the survey had only been advertised once in their newsletter and not for three weeks as initially agreed. The contact person from the other organisation no longer worked there and therefore the survey was not advertised for a further three weeks. Return of the questionnaires from both groups indicated consent to participate in the research.

### **The interviews**

The GP and RN participants were invited to participate in a semi-structured interview via the telephone. This further enhanced the information collected on the participants' perspectives regarding the role of the NP in aged care and factors that affected their ability to provide quality care to the residents. Although it was time consuming and resulted in a large quantity of data to be analysed, this method did enable the researcher to explore other aspects of this topic that were not previously identified in the survey.

### **3.5. Participants**

It is acknowledged by the researcher that the response rates from both groups were small and may be a limitation to this research. However, the analysis of free text information, together with the interviews and comparisons to policy documents freely available on the Internet, supported a far richer data set than the survey alone.

Carrier et al's. (2010) study into RNs' experiences working in aged care in NZ also returned a similar response rate from their participants. Furthermore, Parkinson et al. (2014) discussed the issue that studies undertaken on GPs often returned poor response rates, with recommendations to increase response rates from this cohort being varied. An article

regarding GP response rate to surveys showed that postal surveys had higher return rates than electronic surveys and that to increase this response further, incentives should also be included (Crouch & Robinson, 2011). The use of surveys by mail was further supported by another study that showed 81.1% of GP participants preferred surveys by mail (Bonevski, Magin, Horton, Foster & Girgis, 2011). Other recommendations to improve response rates from GPs were to use a “known and trusted network of professionals to endorse the survey” and to provide substantial financial incentive (Parkinson et al., 2014, para. 1). Although the researcher had access to two reputable professional organisations to send the survey to GPs, the only means of contact given by both organisations for the GPs to access the survey was electronic. With the potential of the response rates from both cohorts being poor, the researcher was guided by Carryer et al’s. (2010) approach, and therefore participants from both cohorts who participated in the survey were also invited to be interviewed.

Whilst there is no way of knowing how many more RNs and GPs might have responded to the survey through word of mouth, the rate of return was considered acceptable for the analysis of data, based on qualitative study guidelines (Malterud, 2001). As discussed by Malterud (2001) “qualitative studies can also be added to quantitative ones, to gain a better understanding of the meaning and implications of the findings” (p. 487). It should, however, be acknowledged that although the free text information supported many of the survey responses, inferential statistics were not used to assist in the analysis of the data because of the possibility of skewed data from such low numbers. As Fisher and Schneider (2013) indicate, large numbers are required when describing statistically significant quantitative analysis, to prevent type II errors occurring.

### **3.6. Ethics**

Schneider et al. (2007) states that “the integrity and honesty of a researcher is critical for the conduct, reporting and publication of studies” (p. 91). Therefore, the researcher acknowledges that it is imperative that ethical standards for research are maintained and that the method, delivery of research, and findings of the proposed research are undertaken honestly and ethically. Ethics approval for this research was gained from the Eastern Institute of Technology’s Research and Ethics Committee (Appendix 1). Anonymity was ensured by posting multiple packs to different facilities and by providing a self-addressed return envelope to the RNs. For the GPs, two separate organisations electronically mailed the survey link in their newsletters to their members. Unless the participant consented to an interview, no identifying information was sought by or given to the researcher. All return envelopes were destroyed. The contact details of those who did provide their names but did not complete the

"Consent to Interview" box were blacked out. All interviews were recorded using a voice recorder. The participants had prior knowledge of this and consented to the interview being recorded prior to the interview commencing. No names were recorded. All the data collected for this research were kept either on a password-locked computer or in a locked filing cabinet.

### **3.7. Cultural considerations**

The NCNZ (2011a) defines cultural safety as

The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.

The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual. (p. 7)

When undertaking research, Schneider et al. (2007) state that the indigenous people of NZ have the right to be protected from researchers passing judgement on cultural aspects, the right to be protected from exploitation, and the right for their culture to be respected with dignity throughout the research. As the definition of culture is not confined to one's ethnicity but rather extends to who the person believes they are, as defined by the NCNZ (2011a) above. The researcher acknowledged this definition and also acknowledged that no one culture is homogenous. Therefore, the researcher is aware that RNs and GPs who provide care to residents requiring hospital-level care in LTACFs will meet the NCNZ'S definition of culture in multiple ways. However, the aim of this research was to explore the perceptions of RNs and GP regarding NP-led care in LTACFs in NZ and not to evaluate or research aspects or areas of culture. Furthermore, no specific cultural group has been identified or targeted for this research and consideration of cultural aspects has not been sought from a Maori Health Co-ordinator. For the purposes of descriptive analysis, the survey included the question: "Are you New Zealand trained?" This question was to provide the researcher with data to determine if there was a difference in perspective regarding NP-led care based on where the individual was trained and not for the purposes of determining participants' cultural or ethnic background.

### 3.8. Data analysis

The quantitative data were analysed using descriptive statistics in the statistical computing package R (R Development Core Team, 2014). Due to the relatively small sample sizes obtained, statistical probability is treated as being only suggestive of a statistical association between variables under assessment. Schneider et al. (2007) state that there are two reasons researchers use this method: the first is to be able to describe the data received and easily determine differences and trends, and the second is to enable the researcher to reduce large quantities of data into "meaningful units" (Schneider et al., 2007, p. 226). The researcher acknowledged that a limitation of this method of analysis is that the researcher can only describe the results received and predictions cannot be made.

All surveys returned by the RN via mail were entered manually by the researcher into the programme Survey Monkey™ so that the spreadsheet generated could easily be uploaded into R. The features of this programme enabled the data to be analysed and trends to be found. The qualitative data were analysed using a process of thematic analysis involving six phases as outlined by the University of Auckland (n.d.). To identify themes, the researcher become familiar with the data through the process of reading and re-reading the data (University of Auckland, n.d.). From the data, information that was considered pertinent to research question were coded. Once coded, the data was used to search for potential themes (University of Auckland, n.d.). The themes were then reviewed. The identified themes were outlined and discussed (University of Auckland, n.d.). The final phase of this process involved the writing up of the themes with existing literature blended throughout the write up (University of Auckland, n.d.). The advantage of this method of analysis gives the researcher the opportunity to draw out themes and information from the interviews that may have been missed from the survey data, providing the researcher with rich data to analyse.

The next chapter will outline the results received from the survey and interviews.

## CHAPTER 4

### Results

#### 4.1 Introduction

The aim of this research was to explore the perceptions of RNs and GPs regarding NP-led care in LTACFs in NZ. The framework used was CST, which allowed for further research to support or refute the findings. The data collection method was a two-step process, the first step consisting of a survey and the second step interviewing the participants. It is known that RNs who work in LTACFs often have poor response rates to research. To minimise this, the RNs had the option of completing the survey online via Survey Monkey™ or returning the survey via mail, with a self-addressed return envelope being provided. The majority of RNs returned the survey via mail. Although the online survey allowed the participants to select only one answer for particular questions, this element was not easily controlled in the hardcopy version, and in some instances, the RNs selected more than one option and/or added comments next to their selection. As the RNs who completed the survey online did not have this option, it was decided to eliminate the hardcopy data where these variants occurred. The GPs had access to the online survey via Survey Monkey™ only and were not provided with a hardcopy option; therefore, this revision was not required for this cohort. For a summary of responses and questions skipped by RNs and GPs, refer to Appendix 3. For a summary of discarded data, refer to Appendix 4. There was a large amount of data gathered in this research that was not anticipated and the author acknowledges that this research has gone beyond the scope of this thesis. Although not all the data have been discussed, data considered pertinent to the research question have been included and will be discussed later.

#### 4.2 Survey

It is acknowledged by the researcher that the response rates from both groups are small and that this fact could be regarded as a limitation to this research. However, CST allows for the analysis of free text information, together with the interviews, comparisons to policy and literature, thus supporting a far richer data set than the survey alone. Robson (1998), says that the exploration of text and commentaries is required to elicit themes from which to analyse information, rather than using statistics alone. When conducting descriptive studies Carspecken (1996) contends that triangulation of data can be executed with a comparative analysis of additional text relevant to the subject, against survey entries. The purpose of triangulation is "to increase the understanding of complex phenomena, not criteria-

based validation, in which agreement among different sources confirms validity" (Malterud, 2001, p. 487). In this research, data was triangulated by analysing the responses to the survey questions and comparing these responses against the free text comments and the responses from the interviews. The researcher did have access to two reputable professional organisations but the surveys were sent electronically. Whilst there is no way of knowing how many more RNs and GPs might have responded to the survey through word of mouth, the rate of return was considered acceptable for the analysis of data, based on qualitative study guidelines (Malterud, 2001). As discussed by Malterud (2001), "qualitative studies can also be added to quantitative ones, to gain a better understanding of the meaning and implications of the findings" (p. 487).

When examining the demographic data, some baseline information was required. According to the NCNZ (2014a), there are 48,406 RNs in NZ. A report detailing the NZ nursing workforce showed that there were 4,259 RNs working in Rest Home/Residential Care in 2013 (NCNZ, 2014b). A criterion of the research was that the RNs needed to be working in LTACFs that had a hospital-level wing as this is an area most likely to be requiring acute clinical support. RN participants were sought by the Researcher who telephoned LTACFs. A total of 34 LTACFs consented for their RNs to participate in this research. A total of 295 packs were posted, with 75 surveys being returned.

The GP participants were sought through two professional organisations that had consented to include a link to the survey in their weekly electronic newsletter to their members. The most current statistics show that there are 3,594 GPs in NZ (Medical Council of New Zealand, 2012). The response rate of the GPs was 24. There was one response returned from a Practice Nurse who had completed the GP survey and this was eliminated from analysis.

The survey data were analysed using R. Descriptive analysis in the form of frequency distribution and Pearson's chi square test were used to analyse the survey data. Prior to the participants answering questions regarding the NP role in LTACFs, the participants were asked to answer questions relating to participant demographics and their workload, the results of which are discussed next. This was done in order to gain insights into the contexts of the work environments of the participants, which may have had an influence on the perceptions offered by the respondents. Where '*n*' is shown in parenthesis after a percentage result this denotes total number of participants who responded to the question.

At a first glance at the survey data, what was immediately evident was the difference in years of experience between the RN and GP cohorts. According to Benner (2001), experiential knowledge influences how people cope with dynamic work environments. It is known that the NZ nursing and GP workforces are ageing, and with that, the capacity to manage high workloads diminishes (Health Workforce New Zealand [HWFNZ] 2012). Therefore, some of the analysis that was undertaken used the experience level as a base.

#### 4.2.1. Participant demographics

Fifty percent ( $n = 22$ ) of the GP group had been practising as GPs for over 30 years, compared to the RN group where the majority (32.9%,  $n = 70$ ) have had 0-5 years of experience. Four point five percent ( $n = 22$ ) of the GP group had been practising for 0-5 years and 24.3% ( $n = 70$ ) of the RN group had more than 30 years of experience. When comparing the 21-30 years of experience, the GP group had the highest percentage of 27.3% ( $n = 24$ ), compared to 11.4% ( $n = 70$ ) of the RNs. There was very little difference between the two groups in the 11-20 year bracket, with the RN group again having the majority of participants in the 6-10 year group (12.9%,  $n = 70$ ) compared to 0% ( $n = 22$ ) of the GP group.

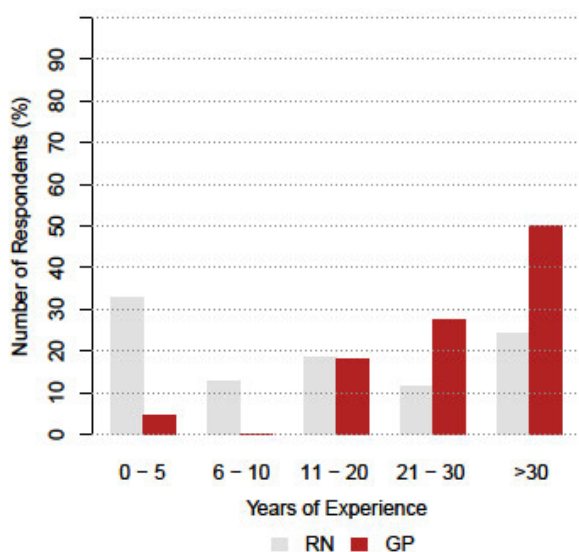


Figure 1. Years of experience shown in percentage for RN and GP groups.

Frequency analysis showed that the RNs with 0-5 years of experience were also the majority ( $f = 21$ ,  $n = 70$ ) of those working in an LTACF for 0-5 years, compared with the other experience levels. The following result ( $\chi^2 (12, n = 66) = 47.65$ ,  $p = <0.001$ ) is suggestive of an association between RN years of experience and years working in an LTACF.

Of the participants, 65.8% ( $n = 73$ ) of RNs and 63.6% ( $n = 22$ ) of GPs had undertaken their training in NZ. The RNs with 0-5 years of experience had the highest number of RNs ( $f = 8$ ,  $n = 73$ ) who had undertaken their training overseas; in contrast, GPs with more than 30 years of experience ( $f = 8$ ,  $n = 22$ ) were the majority of those undertaking their training in NZ.

The participants were asked if they held postgraduate qualifications, and 21.4% ( $n = 70$ ) of RNs and 95.5% ( $n = 22$ ) of GPs stated they did. Twelve percent ( $n = 75$ ) of RN participants stated they were currently engaged in postgraduate study, compared with 13.6% ( $n = 22$ ) of GP participants saying that they were studying.

Frequency distribution showed that RNs with experience above 30 years and those with 0-5 years of experience were equal ( $f = 17$ ,  $n = 75$ ) with regard to those currently not engaged in postgraduate study. RNs with 0-5 years of experience were the majority ( $f = 6$ ,  $n = 75$ ) of those currently engaged in postgraduate study.

Furthermore, the results showed that the RNs with experience above 30 years and those with 0-5 years of experience were again the majority of those holding a postgraduate qualification in nursing.

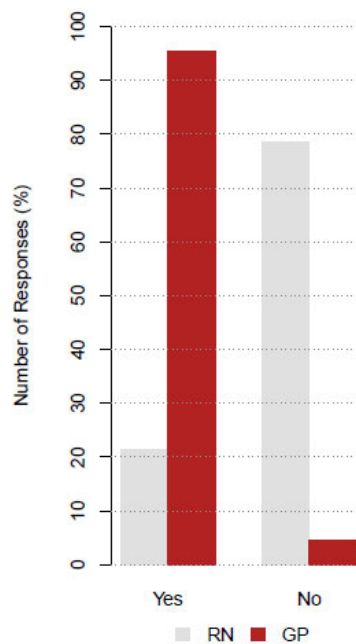


Figure 2. Percentage of participants holding a postgraduate qualification.

Table 1

*Frequency distribution table showing RN years of experience and postgraduate qualifications*

RN years of experience	Holding a postgraduate qualification	
	Yes	No
0-5	5	17
6-10	0	8
11-20	2	10
21-30	2	6
More than 30	6	11

Following on from the question about experience, the RN participants were asked if they had access to professional development opportunities in NZ; 91.8% ( $n = 73$ ) stated they did, with 75.7% ( $n = 70$ ) stating that educational opportunities met their needs. This question was asked because of the registration requirements of RNs in NZ, to demonstrate ongoing learning in their area of practice, in addition to the fact that well known linkages have been found between ongoing education, currency of practice and patient care outcomes (Rosenblum & Sprague-McRae, 2014). From the comments, some participants had access to further education through such avenues as the PDRP<sup>8</sup>, a polytechnic college, their local DHBs, or a Hospice. The equity of such education was variable, with one participant stating that they had to pay for professional development opportunities themselves. Another stated they had to travel for "four hours" to get to relevant training days, and another participant said that their local DHB ceased all training for non-DHB staff and that it was "essential to attend external training provided by experts not employed by this company". However, this latter participant also stated that although their manager was supportive of them attending external training, but the external training available was often not at RN level. Although some RNs indicated that the current professional development opportunities on offer were sufficient, the majority of RNs wanted access to other educational sessions that were "more/higher level of

<sup>8</sup>The PDRP is a "competence based programme that assesses nursing practice against competencies, recognises level of practice and supports ongoing professional development." (National Nurses Organisation, 2004, p. 24). The levels of practice RNs are assessed and recognised against are competent, proficient, and expert level (Future Workforce, n.d.).

*education*" such as dementia, gerontology, audit training, postgraduate study, education appropriate for aged care, *"assessment with clinical decision making skills"*, cardiac, mental health, pharmacology, assessments, IV therapy training, phlebotomy, and immunisation. One RN stated that they and their colleagues had enrolled in a university course on leadership in aged care that was cancelled due to low enrolment numbers.

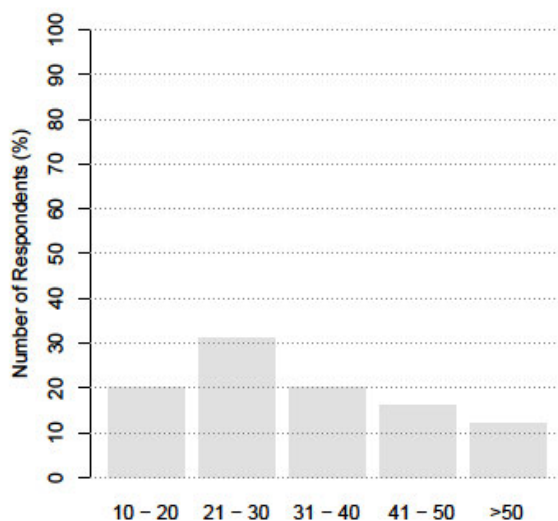
The RN participants were asked what factors affected their ability to access professional development opportunities; the majority cited time as a factor, including the inability to find replacement staff in order to attend study days. Other factors stated were financial/funding reasons. Comments ranged from poor budgets at work, not being paid to attend study days or external study days, management not being supportive and declining requests due to funding, or no funding being available. Two other participants stated that the DHBs provided few educational opportunities or support for further studies, the last factor cited being due to geographical location and distance to travel to study days. Other studies have supported this finding, finding that RNs working in LTACFs in NZ often had poor/limited access to professional development opportunities (Carryer et al., 2010). The literature review process found no literature to suggest GPs had limited opportunities, or poor access, to professional development opportunities. Therefore, the GP participants were not asked questions relating to professional development opportunities.

To summarise, this section shows that the experience levels of RNs working in LTACFs in NZ and the GP experience are at opposite ends of the spectrum. Furthermore, a high proportion of the RNs with 0-5 years of experience have only worked in LTACFs. It is unknown if this experience has been solely in NZ. The RNs with 0-5 years of experience were the majority, having completed their training overseas. Although 91.8% ( $n = 73$ ) of RN participants stated they had access to professional development opportunities, only 75.7% ( $n = 70$ ) stated that these opportunities met their needs. Twenty-one point four percent of RN participants held postgraduate qualifications, compared with 95.5% ( $n = 22$ ) of GP participants. Although the response rate from both groups was small, comments from the RNs regarding access, and factors affecting their access, to professional development opportunities appeared to be an ongoing theme that warrants further discussion.

#### **4.2.2. Workload**

To understand the context of practice and the type of patient profile RNs and GPs were managing, questions around workload were asked. Research showed that the higher the workload, the less likely staff were to manage their workload, and the more stress was

experienced (Purcell, Kutash & Cobb, 2011; Wolosin, Ayala & Fulton, 2012). Therefore, it can be anticipated that the higher the workload, the more likely RNs and GPs would consider an NP role as support for their workload. The RN participants were asked how many hospital-level residents they were responsible for during their 8 hour shift. The category “21-30”



showed the highest overall percentage (31.1%,  $n = 74$ ) for number of residents RNs were responsible for during their 8 hour shift. For the category “more than 50” residents, participants were asked to state the actual number of residents they were responsible for during their shift. The highest number stated was 103 residents, followed by 99 (stated by a Clinical Manager), and 80-100. Other participants stated 54, 56, 58, and 61 residents, respectively.

*Figure 3.* Percentage of RN participants and number of residents responsible for during an 8 hour shift.

GPs were asked if they currently provided care<sup>9</sup> to residents requiring hospital-level care in LTACFs and 69.6% ( $n = 23$ ) of GP participants stated they did. Frequency analysis showed that the GPs with more than 30 years of experience ( $f = 8$ ,  $n = 23$ ) were the largest group providing care to residents living in LTACFs requiring hospital-level care and had the most number of LTACFs with a hospital-level wing in the categories “1-5” ( $f = 5$ ,  $n = 17$ ) and “6-10” ( $f = 3$ ,  $n = 17$ ).

<sup>9</sup> For the purposes of this research, where “providing care” is used in GP questions, it is inferred as medical care and in questions for RNs, it refers to care provided as per the RN scope of practice.

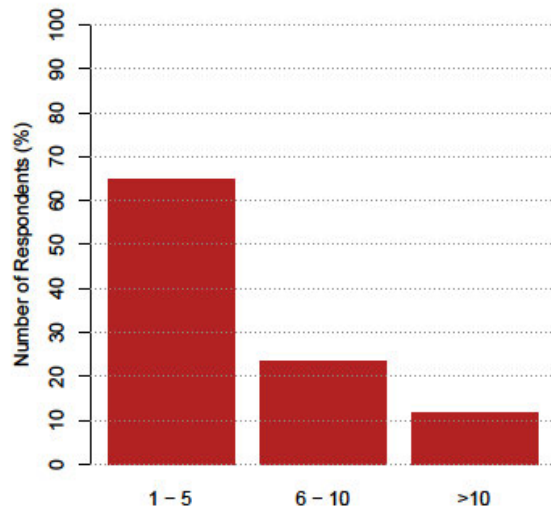


Figure 4. Percentage of GP participants and number of LTACFs.

The category "1-5" showed the highest overall percentage (64.7%,  $n = 17$ ) of number of LTACFs that GPs had as part of their workload. To help with workload, a GP commented that an NP whose principal role would be to review residents in LTACFS had been employed. Two GPs provided reasons as to why they no longer provided care to residents in LTACFs:

*"due to feeling it would be disproportionately difficult compared with other work, and perhaps hard to provide the high standards I am to have in my clinical work", and*  
*"I saw RNs and Health Care Assistants (HCA) being worked off their feet".*

Table 2

*Frequency distribution table showing GP years of experience and number of LTACFs with a hospital wing*

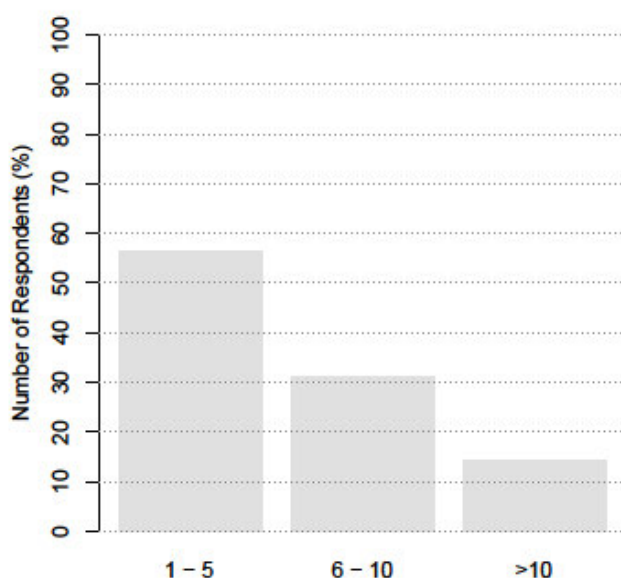
GP years of experience	Number of LTACFs		
	1-5	6-10	More than 10
0-5	1	0	0
11-20	1	1	1
21-30	4	0	0
More than 30	5	3	1

RN participants were asked to state the number of GPs they worked with. Seventy-one point two percent ( $n = 73$ ) of RNs stated they worked with 1-5 GPs, and 17.8% ( $n = 73$ ) of RNs stated they worked with more than 10 GPs.

Over and above the required 3 monthly GP reviews of the residents, the majority of RN participants (56.3%,  $n = 71$ ) stated they asked the GP to review at least 1-5 residents weekly. Thirty-one percent ( $n = 73$ ) stated they asked the GP to review 6-10 residents weekly and 14.1% ( $n = 73$ ) stated above 10. One RN stated that psychogeriatric residents with hospital-level care were required to be seen on a monthly basis. Another RN said that if residents were unstable, they would be seen monthly and that any resident who became acutely unwell was sent to the GP surgery. One RN said that they had residents who requested to see the GP weekly, in addition to which the GP saw 15-20 residents weekly due to "ongoing complex issues".

Three of the RNs commented that they had set days when the GP visited. The RN who stated that the GP visited twice a week indicated that the GP could see "on average +/- 20 residents". One of the RNs stated that the GP had clinics 3 days a week and would see approximately 5-10 residents in each clinic. Another RN stated that "occasionally above 10 (up to 18) often because symptoms presenting obviously require blood tests or medication changes".

The RNs with 0-5 years of experience were the highest number in the categories 1-5 ( $f = 13, n = 71$ ) and 6-10 ( $f = 7, n = 71$ ) regarding number of residents they would request the GP to review weekly.



*Figure 5. Percentage of RN participants and number of weekly resident reviews by GP.*

The GPs were asked to state approximately how many patients they would see in their general practice/after hours weekly. Thirty-one point six percent ( $n = 19$ ) of GPs stated they saw approximately 30-60 patients in their practice/after hours weekly. As this question did not stipulate that the GPs should not include patients from LTACFs, it is unclear if GPs had included them in their numbers when answering this question. Twenty-six point three percent ( $n = 19$ ) of GPs stated they saw 10-30 and 60-90 patients weekly. Fifteen point eight percent ( $n = 19$ ) of GPs said they saw more than 90 patients weekly. The GP participants were asked to state how many patients they saw weekly if above 90. The number of patients seen weekly ranged from 100 to 150. It was, however, unclear if these high numbers were due to the GPs' including any work they did in Accident or Medical facilities that might form part of their workload. GPs with more than 30 years of experience saw the most number of patients weekly in the categories 10-30 ( $f = 3, n = 19$ ), 30-60 ( $f = 4, n = 19$ ), and more than 90 ( $f = 2, n = 19$ ) compared with the GPs with other years of experience. There were no selections made by those with 0-5 years of experience in categories 30 and above, and only one GP with 0-5 years of experience stated they saw 10-30 practice patients weekly. It is not clear why GPs with less experience did not provide care to the aged care sector, and this will be raised again in the Discussion chapter.

Furthermore, the GP participants were asked if they believed there was a shortage of GP services in their area, and 69.6% ( $n = 23$ ) stated "yes". This question was asked because, anecdotally, there is a perception that there is a shortage of GP services in NZ, which impacts on the services provided to LTACFs, supporting the NP role as bridging the gap of service provision. The GP participants with more than 30 years of experience ( $f = 10, n = 23$ ) were the majority who believed there was a shortage of GP services in their area. One GP commented that

*"many practices have more enrolled patients than they can service. Patients who cannot be seen by their GPs spill over in A&M service where I work and where they pay a high fee. This is obviously not used if patients cannot get there or afford it".*

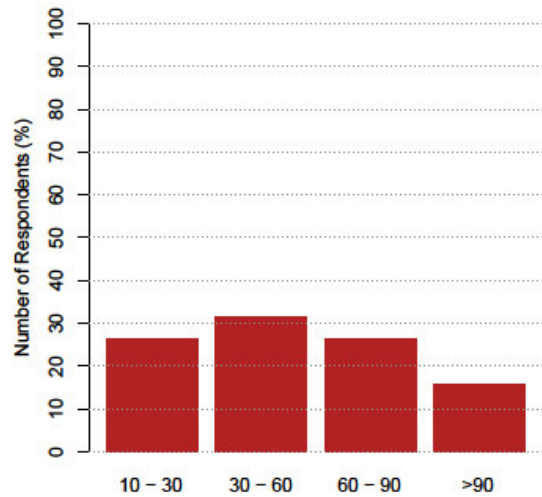


Figure 6. Percentage of GP participants and number of patients seen weekly.

Both groups were asked if they believed it was possible for the GP to review residents assessed as urgent by the RN immediately. Seventy-five point three percent ( $n = 71$ ) of RNs and 73.7% ( $n = 19$ ) of GPs stated that it was not always possible. The participants were asked when a GP review of a resident considered urgent by the RN would most likely occur. Twenty-three point three percent ( $n = 60$ ) of RN participants and 18.8% ( $n = 16$ ) of GP participants selected “immediately”. The highest percentage of participants (50% of GPs,  $n = 16$  and 45%,  $n = 60$  of RNs) selected the “in between seeing the practice patients”, followed by 31.7% ( $n = 60$ ) of RNs and 31.3% ( $n = 16$ ) of GPs stating the resident would be sent to hospital via an ambulance. The majority of the comments stated that it was a rare occasion that a resident needed urgent review and that it was unreasonable to expect the GP to attend immediately, especially if the GP was off site. Other comments were

*“He has other facilities (LTCFs) to visit”*

*“Has a regular practice”*

*“No, it is entirely impractical he has full days at his practice. If we have someone acutely unwell, we call an ambulance, doesn't happen very often”.*

Although the general consensus was that if a resident required urgent review, the GP would either give verbal orders over the phone or the resident would be sent to hospital via an ambulance. There were a few comments that were mixed regarding an urgent situation:

*“I feel in an urgent situation that someone should review the resident – even a duty GP or Nurse Practitioner”.*

*"Not enough medical staff"*

*"Periodically frustrating but mostly manageable, using interim nursing measures. With an NP the "next step" for managing would be available".*

*"There are no GP available on weekends, urgent cases have to be sent to the hospital"*

*"Their own practice patients take precedence (even though their aged care residents is part of their practice!)"*

*"We have an excellent GP coverage - in all the time I have worked here would only have made the call to send someone in an ambulance as unable to reach GP two times"*

The response from the GPs was similar to the RNs' and the consensus was that the resident would be reviewed the same day, either in the GP's lunch break, after work, or the next available time. A GP stated that urgent cases could usually be sorted out over the phone, but that if this was not possible, after work on the same day *"is early enough"*. This comment was supported by another GP who stated that a decision in consultation with the nursing staff would be made whether the resident could be managed in the LTACF, or in hospital, or be sent to the GP practice. If possible, the nursing staff would start treatment and the GP would review that day when it was possible. Another GP whose practice was solely in LTACFS stated, that during working hours, they were able to respond promptly but, after hours, their response *"can be a little delayed. An available Nurse Practitioner would be most helpful"*. One GP stated they have *"an accident and medical facility attached to our practice"* and another stated *"we have a 7 doctor group practice -If I cannot attend then the patient may be seen urgently by another Dr from our practice"*. The results showed that the highest number of GP participants with 1-5 LTACFs ( $f = 8, n = 17$ ) would review a resident considered urgent by the RN in between seeing their practice patients. The following result ( $\chi^2(4, n = 15) = 12.36, p = 0.014$ ) is suggestive of an association between GPs with 1-5 LTACFs and urgent review of residents.

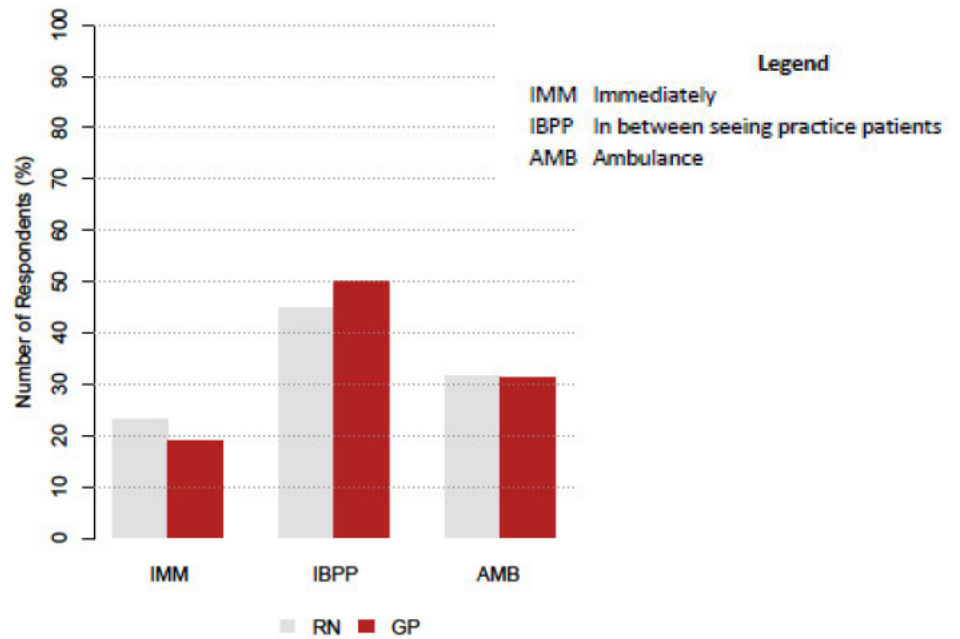


Figure 7. Review of urgent resident cases by GP.

When requesting a GP to review a resident, 98.6% ( $n = 74$ ) of RN participants believed they gave a clear handover to the GP, compared to 66.7% ( $n = 18$ ) of GPs who believed they received a clear handover from the RN. Furthermore, 86.1% ( $n = 72$ ) of RN participants stated they used the Identify, situation, background, assessment, and recommendation (ISBAR<sup>10</sup>) method to handover to the GP. The RNs with 0-5 years of experience were the majority ( $f = 23$ ) of those who said they gave a clear handover and the majority of those who used the ISBAR method ( $f = 5$ ). The GPs with more than 30 years of experience ( $f = 8$ ) were the majority of those who agreed they received a clear handover from the RNs, compared to a GP with 0-5 years of experience ( $f = 1$ ) who stated they did not get a clear handover from the RN. In light of the comments below, this question poses limitations in that it does not allow the cohorts to independently distinguish quality of handover and years of experience. They are only able to do so in the free text comments box provided.

Although the response rate and comments from the RNs regarding their method of handover is favourable, the comments from the GPs lean towards the need for further improvement in this area. One GP stated *“there are often very junior graduates dealing with this especially in an after hours situation. A more experienced nurse - often the clinical*

<sup>10</sup> ISBAR is a tool used to safely communicate information which is considered critical. The purpose of the ISBAR tool is to improve safety, in this case resident safety, when handover of resident information is occurring between health professionals (Government of South Australia, 2012).

manager is invaluable in providing adequate handover". This comment was supported by another GP who stated, "although have to admit quality of RN's at LTACF can vary enormously from poor to great". Other comments were:

*"usually, quite often things are not urgent, and there seems to be legal/ family/ paperwork / responsibility ducking pressure in the homes instead"*

*"can be variable depending on the skills of the RN"*

*"NO often the nurse available has been away on days off (and doesn't know what has been done recently), or pulled from another wing. I often have to speak to a caregiver. Often the IMP for prn<sup>11</sup> meds has to be retrieved from somewhere else (in facilities that don't have e-Prescribing)"*

*"we do now we have insisted on a clear indication of the patient stats -ie bp pulse temp resps level of consc urine dipstix .then the triage at our surgery can be a lot more accurate and sometimes the visit is not required"*

*"However, it is often not the RN who made the request as she/he has gone off duty"*

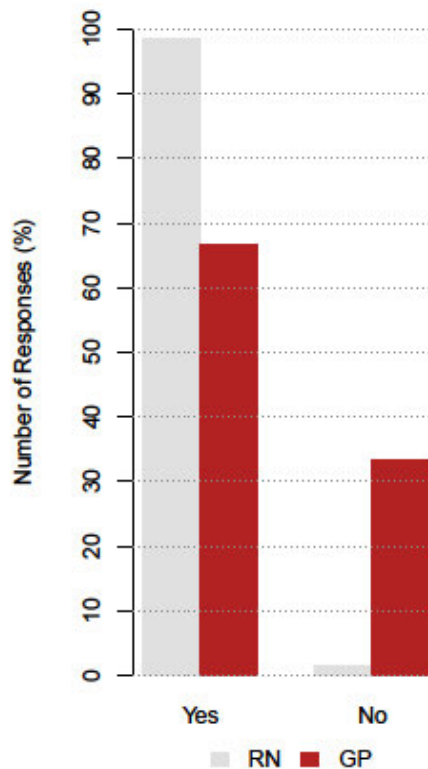


Figure 8. Percentage of participants and clear handover given to GP.

<sup>11</sup> Pro re nata

Regarding review of non-urgent residents by GP, the options given were “during lunch break”, “after practice patients have been seen for the day”, “the next morning on their way to work”, and “immediately”. The majority of RN participants ( $n = 42$ ) selected the statement “after the practice patients had been seen for the day” and 16.7% ( $n = 42$ ) of RN participants stated the GP would come during the GP’s lunch break. The majority of GP participants ( $n = 14$ ) stated they saw the residents during their lunch break and after the practice patients had been seen for the day. Twenty-six point two percent ( $n = 42$ ) of RNs stated the GP would come the following morning on their way to work, compared to 14.3% ( $n = 14$ ) of GP participants who said they did so. Eleven point nine percent of RNs ( $n = 42$ ) stated the GP will come immediately compared with 0% ( $n = 14$ ) of GP participants who said they would do this.

Although these results and commentaries are significant in themselves, the response number for statistical significance was too small to make a more detailed comparison. The point to note here is that very often the review of residents appears to be fitted in between routine GP practice work, and that communication between the RN and GP is a pivotal component of effective care. Additionally, the experience of the RN in providing relevant information to the GP on the resident’s condition is important, and this point has come through in the commentaries of the GPs earlier in this chapter in regard to handover.

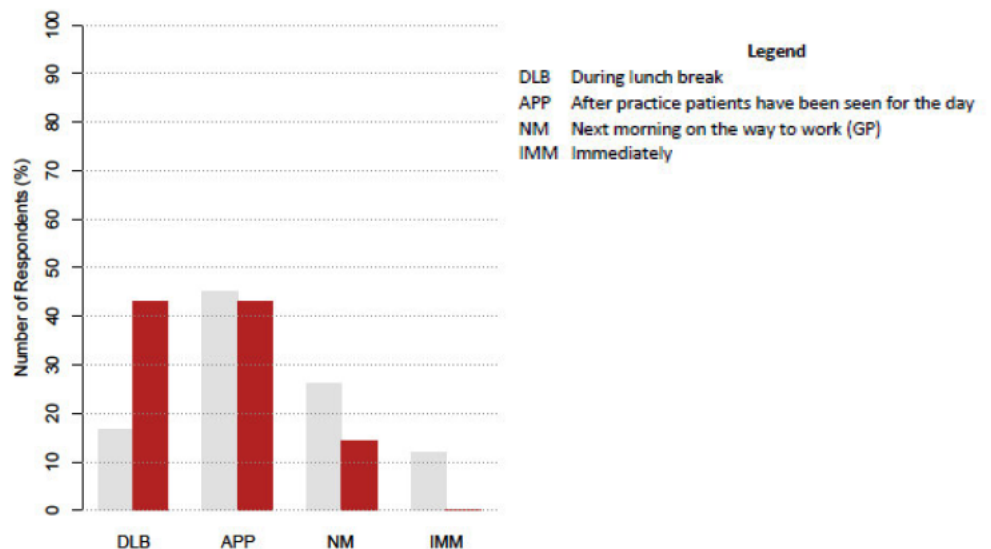


Figure 9. Review of non-urgent resident cases by GP.

Quality of care in aged care has been the focus of attention nationally. In order to ensure the care provided to residents in LTACFs is appropriate and safe, LTACFs are certified and are regularly audited by designated auditing agencies under the Health and Disability Services (Safety) Act (2001). Furthermore, under the Aged Residential Care Contract (ARCC), DHBs can also request audits be conducted if issues or resident complaints arise

(MoH, 2013a). It is anecdotally well known that in order to meet the requirements outlined in the Act, a considerable amount of paperwork is required to be completed on each resident by the RNs and GPs, the completion of which impacts on their already demanding workload.

Both groups of participants were asked if they thought that the mandated audits under the Health and Disability Services (Safety) Act (2001) had assisted in identifying/improving the safety and care provided to residents in LTACFs. Both groups (92.8% of RN,  $n = 69$  and 55%,  $n = 20$  of GP participants) were of the opinion that the Act had assisted in identifying/improving the safety and care of residents, although the volume of work it involved was noted. One RN stated that *"If there were no mandatory standards to be met, some LTACFs would be substandard and not a place you would want your loved one to be cared in. 'Cutting corners' would occur if there was no monitoring"*. Other RNs focused on the relationship between the findings of the auditors and the care provided to residents, in some cases, negatively influencing their perceptions of this activity. These comments were:

*"To a certain extent. Some of the comments/findings are quite "picky" – would in no way improve or be detrimental to Health care"*

*"I believe some areas of concerns found by them are not at all important on the quality of the care provided".*

*"I'm unsure of this. Obviously there is a need for standards and standardisation and measurements for safety. However, because of staff numbers, I often feel the amount of documentation detracts from time spent on "actual" quality care".*

*"They are just reports on paper, unless the recommendations are put in practice, and that all care staff are well supported in implementing them, it would be difficult to improve the health system in the facilities. Care staff are run down with do's and don'ts in providing care for the residents, with the additional documentations they need to provide, but in reality, the care staff-patient ratio is alarmingly disproportional that whatever the findings of the auditors are in improving the safety and care provided would become futile unless they see the actual situations in the LTACFs".*

*"But I am a full supporter of revised safe staffing guidelines, not the pitiful minimum levels in the residential care contracts. I believe unannounced audits in combination with increased staffing levels would provide the safest care for our residents!"*

These thoughts were shared by the GPs:

*"my impression of audits is that they do not generate a culture of excellence or compassion per se", "marginal improvement",*

*"The items that are audited are not necessarily those that improve care but are those that are measurable. Nit-picking and not looking at important issues", and "not to a degree that makes the disruption of care that is created by the intrusion worth the hassle .education of the Homes would work better-they try hard and are professional now".*

Another GP stated that although they did not have any actual evidence to state if the audits improved care, they would rather *"talk to an old fashioned nurse who really knows the patient and their family than someone who has been ticking boxes for half their shift and who lives in fear of the next audit and who rushes up to me asking for me to sign multiple pieces of paper to keep the auditors happy!"*.

The GPs tended to focus on the amount of paperwork that was required. One GP stated that there was a large amount of paperwork that was perhaps *"repetitive"* and *"unnecessary, and eats into patient care time"* and another GP stated:

*"...partly. Seems overemphasis on paperwork. They should have to demonstrate an evidence base for their quality measures. I've had nurses beg me to rewrite IMPs that have been faxed (usually for another patient that I wasn't scheduled to see) ...why, if they're still legible? Some silly rules (like 48 hour deadlines)."*

Comments made by two other GPs were that the audits tended to be particular over *"irrelevant issues of paperwork"* and *"Some failings as they have been based on paper compliance, not enough on quality, culture, person-centredness etc"*.

To summarise, the resident/patient ratio to RNs and GPs is high. More than half of the GP participants were of the opinion that there was a shortage of GP services in their area. Even though residents requiring urgent review by GPs were considered a rare event, both groups agreed that it was not always possible for the GP to review these residents immediately and the majority said that the resident would be sent to the hospital via an ambulance. This finding demonstrates another emerging theme throughout that is supported by the literature regarding the high incidence of avoidable admission rates of the elderly from

LTACFs to the ED (Foster et al., 2012; Turrell & Castleden, 1999). Lastly, despite the fact that both groups were of the consensus that auditing of the LTACFs did identify/improve the safety and care provided to residents, the participants expressed that a large amount of their time was taken up in order to meet these requirements, which meant that their time was taken away from the residents. The comments made regarding the amount of paperwork needed to meet audit requirements, certain issues the auditors focused on, the amount of time maintaining audit requirements, and time taken away from residents seemed to be issues for both groups.

#### 4.2.3. Perception of NP role

Participants were asked if they had heard/read about NPs prior to receiving this survey and if they had discussed with other doctors or nurses the idea of NPs providing health care in LTACFs. The results showed that 95.8% ( $n = 72$ ) of RN participants and 100% ( $n = 24$ ) of GP participants had heard/read about NPs. Thirty-eight point nine percent ( $n = 72$ ) of RN participants stated they had not discussed the idea of NPs providing health care in LTACFs, compared to 58.3% ( $n = 24$ ) of GP participants who stated they had discussed this.

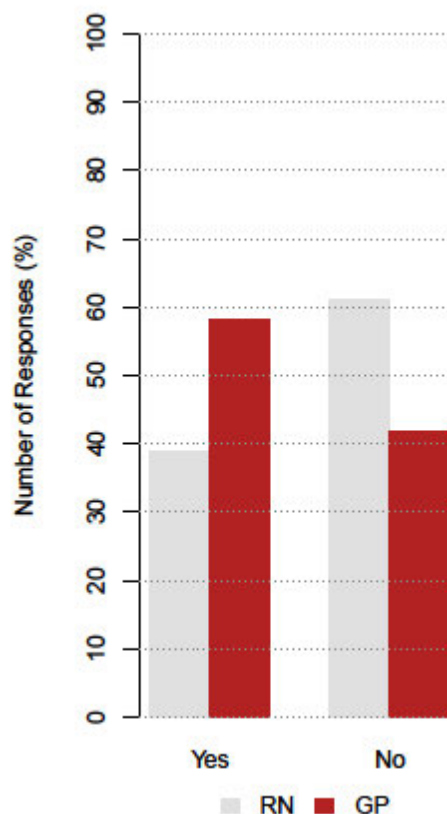


Figure 10. The percentage of RNs and GPs who have discussed the idea of NPs providing health care in LTACFs.

Two questions regarding the role of the NP in LTACFs were asked of both groups of participants: "In your opinion, would the services of an NP enhance the delivery of health care in LTACFs?" and "In your opinion, do you think an NP can improve access of care to residents in LTACFs". Both groups were of the opinion (87%,  $n = 69$  of RNs and 81.8%,  $n = 22$  of GPs) that an NP could enhance the delivery of health in LTACFs. The statistical results suggest an association ( $\chi^2 (1, n = 16) = 7.47, p = <0.02$ ) between the number of LTACFs GPs were responsible for and whether the GP thought an NP could enhance the delivery of health care in LTACFs. The following results ( $\chi^2 (4, n = 70) = 9.63, p = <0.04$ ) are suggestive of an association between the number of residents RNs were responsible for during their 8 hour shift and whether the RN thought an NP could enhance the delivery of health care in LTACFs.

With regards to the latter question, 93% ( $n = 71$ ) of RNs and 83.3% ( $n = 18$ ) of GPs were of the opinion that NPs could improve access of care to residents in LTACFs. For both groups, the following results RN ( $\chi^2 (1, n = 65) = 19.78, p = <0.001$ ) and GP ( $\chi^2 (1, n = 18) = 11.52, p = <0.0001$ ) suggested of an association between these two questions. RN participants with the experience of more than 30 years ( $f = 17$ ) and 1-5 years ( $f = 19$ ) were the majority in believing an NP could enhance the delivery of health care in LTACFs, compared with the GPs with more than 30 years of experience ( $f = 9$ ) being the majority.

Some comments from the RNs stated that:

*"In the absence of the GP, NPs carry out monthly reviews w/c lessens the load of GP",*

*"NPs can, and do, ease the GPs' burden of care, and have the unique perspective of the nurse",*

*"Takes the load off the GPs", and*

*"I currently work with Nurse Practitioners supporting the GP service. I was always a supporter of this type of practice, and realise how effective it can be since this has been put in place".*

Many of the comments received by the RNs around these questions tended to focus on the possibility that the NP might be more accessible than the GP, in that the NP could be used to provide more timely interventions for urgent reviews and infections: *"would be excellent - UTI<sup>12</sup> could be treated easily, saving time of the GPs having to frequently visit".* A point raised by an RN was that the NP focus would need to be solely on the LTACFs and not

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<sup>12</sup> Urinary tract infection

fulfilling other roles; otherwise the NP would become *“just as busy as GP and then nothing changes”*. One RN stated that *“It is becoming increasingly difficult to organise GP consults for our residents, especially within the 48hr window for new admissions, and when requesting visits outside of the three monthly reviews”*. An RN commented that if the NP was given *“enough time”* they may be able to make a difference, whilst another RN stated that the NP role may cause conflict with the GP, resulting in the delivery of health care in the LTACF being compromised. Furthermore, this RN stated that the *“GP may put all the responsibilities to the NP”*. One RN was concerned that the use of an NP might place added costs on the LTACFs, whilst another RN wondered if an NP might be cheaper than a GP. Two RNs commented that the NP would need to liaise with the GP to start treatment because the GPs had known the patients for several years, and one RN stated NPs could be beneficial as long as *“they use the experience of the staff who care for the residents”*. As well as enhancing the delivery of health care in LTACFs, one RN stated that the NP could be *“an expert resource person as well as advocate. Aged care [was] often perceived as the “poor relation” of nursing - NP input would help improve image”*, whilst helping to decrease avoidable admissions to the DHBs.

The GPs' comments focused on the role of the NP working in collaboration with them. A GP commented that with regards to the limited number of GPs not wanting to engage in this type of care, NPs would provide *an alternative and good options* rather than use the word *“enhance”*. One GP commented that *“not if it means the patient loses contact with their GP - it may help with the paperwork”* whilst another GP stated the NP role could enhance the delivery of health care *“because these patients are so complicated they need specialised help”*. One GP stated that the *“quality of the NP”* would be the influencing factor as to whether the NP would enhance the delivery of health care in LTACFs. Two GPs commented on the scope of the NP, with one saying *“possibly with the supervision as the scope of practice of a nurse is different from GP”* and the other saying *“Nurse Practitioners are NURSES not medically qualified doctors. At the end of the day the GP has responsibility for the overall health of their private practice patients as they are responsible for prescribing medication etc. and if something goes wrong the GP is accountable to the HDC.<sup>13</sup> If NPs want that responsibility then they need to go to Medical School for 12 years and train to become a GP”*. However, the former GP was concerned that the LTACFs would prefer to use *“(cheaper) nurses than (more expensive) GPs”* as LTACFS are *“often profit driven and cost concerned”*. Furthermore, a GP stated that, in their area, the LTACFs had *“limited registered nursing staff owing to cost”*. The GP added that, due to this issue, the ED had a greater rate of unnecessary admissions and

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<sup>13</sup> Health and Disability Commission

the *“surgery telephone triage nurse is inundated with requests for GP visits to the homes that could easily be dealt with by a competent nurse”*. To help with this issue, the GP stated that the LTACFs were considering having their own house GP, which this GP respondent thought to be *“cost inefficient for minor problems”*.

The question *“In your opinion, do you think an NP can improve access of care to residents in LTACFs”*, generated some different and mixed comments from the GP participants. Of the GPs who commented, three believed that an NP could improve access of care to residents in LTACFs. One GP said that an NP’s nursing standard might be more developed than the RNs’ they had come across in LTACFs, whilst another GP thought that if the triaging could be improved, this would be beneficial as the NP might be able to see the resident for better triaging, with the NP being able to take *“some responsibility by diagnosing and initiating treatment, e.g. urine infections, cellulitis, chest infections”*. Although one GP appeared favourable to the NP role, the commentary was on the fact that *“the more registered nurses the better; however who pays? We already have a very poorly paid work force on aged care, with some corporate ones making huge profits! Elderly people often have low fixed incomes or else very clever trusts and assets locked away, so not much cash available to pay for good health care”*. Another GP stated that staff in LTACFs would be able to improve their assessment skills and increase resident contact if there was less paperwork. Two GPs focused on the role of the NP being in collaboration with GP, with one stating:

*“Mostly. NPs MUST BE WILLING to work in collaboration and not be Lone Rangers (trying to save the world- especially those with a chip on their shoulders against doctors or those who are insecure about their role and resist suggestions make it very hard) . This observation from working in other areas with NPs. What I have seen in our area are nurse practitioners have been brought in by the LTACF without informing the doctors or clarifying what their role is...this leads to unnecessary confusion”*.

When the participants were asked if they were willing to work in collaboration with the NP, one GP stated *“I don't have a lot of time for NPs and thank goodness none of my practice nurses wish to be one”*. Despite this comment, the results showed that both the RN and GP groups were favourable to working with an NP, with 95.9% ( $n = 73$ ) of RN and 90.9% ( $n = 22$ ) of GP participants stating they would be willing to work with an NP. From the GPs comments, five GPs had experience with working with NPs and rated this experience positively. Other comments made were

*"I would encourage the development of a comprehensive NP service", and*

*"Since New Zealand struggles to maintain its physician workforce for long term care, palliative care, and oncology, I believe NP's would be a practical, sustainable solution for servicing patients in New Zealand and improving access to care."*

One GP stated that they would need to know what the NP's capabilities were, and if the care provided was *"safe standard care that any reasonable GP in NZ would be happy with and there was NO LEGAL RISK"*, and that a mutually agreed contract would need to be developed. Another GP stated that they would need to be kept informed of their residents' health and any changes made. However, this GP also stated that *"I would prefer that the NPs role was to educate and co-ordinate the nursing team and to prevent falls and accidents than to take over the role of diagnosis and treatment"*.

Different functions of the NP role were outlined and, using a Likert Scale, participants were asked to rate how they personally felt about the NP completing these functions. Options given were "Highly Favourable", "Favourable", "Uncertain", "Unfavourable", and "Highly Unfavourable". The role functions and the participants' responses to these functions are discussed next. Full results are presented in Table 3.

Overall, the RN responses were generally favourable (i.e. either favourable or highly favourable category responses) to the outlined role functions of the NP. The below listed role functions were dominant in the "favourable" category:

- makes the initial assessment of an individual's health-illness status when he or she enters the health care system ( $n = 74$ )
- prescribes medications with doctor collaboration ( $n = 74$ )
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor ( $n = 74$ )
- initiates treatment and therapeutic regimens of commonly occurring, acute health problems of individuals according to standing orders authorised by a doctor ( $n = 74$ )
- manages stabilised, long-term and chronic illness of individuals in all age groups ( $n = 72$ )

As with RNs, GP responses were generally favourable (i.e. either favourable or highly favourable category responses) to the outlined role functions of the NP. For most role functions, the majority of GPs provided favourable responses, with exceptions of the following role functions being "highly favourable":

- provides health teaching ( $n = 22$ )
- undertaking the residents' 3 monthly review" being highly favourable ( $n = 22$ )

Key similarities between RN and GP responses were favourable towards the NP completing the following role functions:

- undertaking the initial assessment of an individual
- prescribing medications with doctor collaboration
- prescribing medications as per the appropriate Medications Act
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor
- initiates treatment and therapeutic regimens of commonly occurring, acute health problems of individuals according to standing orders authorised by a doctor
- manages stabilised, long-term and chronic illness of individuals in all age groups

Role functions that were selected as highly favourable by both groups were

- provides health teaching to patient and family in order to maintain or promote health, and to prevent illness
- undertakes the residents' 3 monthly review
- coordinates health care of individuals and family referral to other health professionals and/or community agencies

The following role functions were selected as highly favourable by the majority of RNs and as favourable by the majority of GPs:

- performs a physical examination
- recommends plan for health care to patient and family based upon clinical findings and in consultation with a doctor

- makes home visits to do follow-up evaluations of the condition of the patient and their family
- obtains and records the patient's and family's health history
- using written guidelines, makes decision regarding when to refer patient to a doctor
- manages routine health care of essentially well individuals
- orders routine laboratory studies as indicated
- participates with doctor in continuous evaluation of the quality and effectiveness of health care
- provides counselling regarding the health–illness problems of the individuals and families
- contributes towards the education opportunities of others in LTACFs
- the overall concept of the NP role

For each role function the second option most selected by RNs was “uncertain” with a small number of RNs selecting “unfavourable” for the following role functions

- makes the initial assessment of an individual's health–illness status when he or she enters the health care system
- prescribes medications with doctor collaboration
- prescribes medications as directed under the appropriate Medications Act
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor
- provides health teaching to patient and family in order to maintain or promote health, and to prevent illness
- coordinates health care of individuals and family referral to other health professionals and/or community agencies
- with written guidelines, makes decision regarding when to refer patient to a doctor
- orders routine laboratory studies as indicated

- manages stabilised, long-term and chronic illness of individuals in all age groups
- provides counselling regarding the health–illness problems of the individuals and families
- provides counselling regarding the health–illness problems of the individuals and families

The category “Highly Unfavourable” returned one RN response for

- prescribes medications as directed under the appropriate Medications Act
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor

For each role function the second option most selected by GPs was “uncertain” with a small number of GPs selecting “unfavourable” for the following role functions:

- makes the initial assessment of an individual's health–illness status when he or she enters this health care system
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor
- recommends plan for health care to patient and family based upon clinical findings and in consultation with a doctor
- manages routine health care of essentially well individuals
- contributes towards the education opportunities of others in LTACFs

And “Highly Unfavourable” for “orders routine laboratory studies as indicated”.

The category “Highly Unfavourable” returned one response from GPs for

- makes the initial assessment of an individual's health–illness status when he or she enters the health care system
- evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor
- performs a physical examination
- makes home visits to do follow-up evaluations of the condition of the patient and their family

- obtains and records the patient's and family's health history
- coordinates health care of individuals and family referral to other health professionals and/or community agencies
- with written guidelines, makes decision regarding when to refer patient to a doctor
- provides counselling regarding the health–illness problems of the individuals and families
- overall, how do you feel about the nurse practitioner concept?

There were two responses for “undertakes the resident's 3 monthly review”.

Table 3

*Participant responses to NP role functions*

NP Role Functions	Response (%)										<i>n</i>	
	Highly Favourable		Favourable		Uncertain		Unfavourable		Highly Unfavourable			
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP
Makes the initial assessment of an individual's health–illness status when he or she enters the health care system	25.7	31.8	47.3	40.9	17.6	9.1	9.5	13.6	0	4.5	74	22
Prescribes medications with doctor collaboration	36.5	31.8	50	45.5	12.2	13.6	1.4	9.1	0	0	74	22
Prescribes medications as directed under the appropriate medications Act	40.5	13.6	40.5	50	14.9	22.7	2.7	9.1	1.4	4.5	74	22
Evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor	41.9	27.3	45.9	59.1	9.5	4.5	1.4	9.1	1.4	0	74	22

NP Role Functions	Response (%)										<i>n</i>	
	Highly Favourable		Favourable		Uncertain		Unfavourable		Highly Unfavourable			
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP
Provides health teaching to patient and family in order to maintain or promote health, and to prevent illness	51.4	45.5	39.2	40.9	8.1	9.1	1.4	4.5	0	0	74	22
Performs a physical examination	52.8	27.3	37.5	40.9	9.7	22.7	0.0	4.5	0	4.5	72	22
Recommends plan for health care to patient and family based upon clinical findings and in consultation with a doctor	50.7	22.7	43.8	59.1	5.5	9.1	0	9.1	0	0	73	22
Makes home visits to do follow-up evaluations of the condition of the patient and their family	43.7	27.3	38.0	50	18.3	18.2	0	0	0	4.5	71	22
Initiates treatment and therapeutic regimens of commonly occurring, acute health problems of individuals according to standing orders authorised by a doctor	44.6	22.7	50	59.1	5.4	13.6	0	4.5	0	0	74	22

NP Role Functions	Response (%)											<i>n</i>	
	Highly Favourable		Favourable		Uncertain		Unfavourable		Highly Unfavourable				
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	
Obtains and records the patient's and family's health history	47.3	40.9	43.2	45.5	6.8	4.5	2.7	4.5	0	4.5	74	22	
Undertakes the resident's three 3 review	37.8	31.8	37.8	27.3	20.3	18.2	4.1	13.6	0	9.1	74	22	
Coordinates health care of individuals and family referral to other health professionals and/or community agencies	43.2	40.9	40.5	40.9	14.9	13.6	1.4	0	0	4.5	74	22	
With written guidelines, makes decision regarding when to refer patient to a doctor	43.1	27.3	38.9	45.5	16.7	22.7	1.4	0	0	4.5	72	22	
Manages routine health care of essentially well individuals	45.8	22.7	41.7	63.6	12.5	4.5	0	9.1	0	0	72	22	
Orders routine laboratory studies as indicated	45.2	18.2	41.1	68.2	12.3	4.5	1.4	0	0	9.1	73	22	

NP Role Functions	Response (%)											<i>n</i>	
	Highly Favourable		Favourable		Uncertain		Unfavourable		Highly Unfavourable				
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP	
Manages stabilised, long-term and chronic illness of individuals in all age groups	40.3	18.2	45.8	40.9	12.5	22.7	1.4	9.1	0	9.1	72	22	
Participates with doctor in continuous evaluation of the quality and effectiveness of health care	52.8	36.4	41.7	40.9	5.6	18.2	0	4.5	0	0	72	22	
Provides counselling regarding the health–illness problems of the individuals and families	47.9	18.2	41.1	63.6	6.8	13.6	4.1	0	0	4.5	73	22	
Contributes towards the education opportunities of others in LTACFs	55.6	40.9	38.9	50	5.6	4.5	0	4.5	0	0	72	22	
Overall, how do you feel about the nurse practitioner concept?	54.8	36.4	37.0	40.9	5.5	13.6	2.7	4.5	0	4.5	73	22	

<sup>a</sup> The count of skipped number of responses includes discarded data. Discarded data included in Appendix 4.

Following on from the question regarding the NP role functions, the participants were asked to rate, on a Likert Scale, how the NP role would be used and viewed by others; others being patients, other RNs, and other GPs. The options given were “no problems at all”, “very few problems”, “some problems”, and “many problems”.

Both groups selected a general “favourable”, with the “very few problems” option regarding how the NP’s role would be viewed by other RNs and patients. The majority of RNs (42%,  $n = 69$ ) believed that there would be “some problems” with the doctors’ acceptance of an NP, whereas the majority of GPs (52.4%,  $n = 21$ ) stated that there would be “very few problems” regarding the nurses’ acceptance of the NP. Thirty-eight point one percent ( $n = 21$ ) of GPs selected the options “very few problems” and “some problems” regarding the GPs’ acceptance of an NP. Both groups (54.4%,  $n = 68$  of RNs and 57.1%,  $n = 21$  of GPs) were in the majority for “some problems” regarding the availability of funds to cover NP services. The majority of GPs (50%,  $n = 22$ ) were of the opinion that there would be “some problems” with the NP role demanding their time either for supervision or consultation, compared with the majority of RNs (45.7%,  $n = 70$ ), who selected “very few problems”.

Results for the perceived use of the NP role, and acceptance by others, are detailed in Table 4 below.

Through the use of a free text box, participants were given the option to add any additional comments regarding the NP role. The comments received from the RNs tended to favour the idea of the NP role, with comments such as *“a great asset to aged care”* and *“the sooner the better!”* Two RNs expressed concern over the NP role, with one stating *“worry about RN role and RNs stop developing”* and *“interference with GP and facility staff and management relationship”*.

The GP participants were mainly concerned over the funding of the NP, and that, if funded correctly, the role might be as costly as the GP, although it was acknowledged that help was needed to manage *“the demands and complexity”* of the residents. One GP commented that the NP role might be a *“duplication of resources”*, and another GP stated that the role of the NP could possibly increase the tension among GPs, who are very *“patch protective”*. Furthermore, one GP was concerned that the training required to get the NP up to the standard to care for these residents might be very costly and time consuming. However, the GP was willing to trial the idea. A GP said that *“government legislation needs to increase pay to the sector in general and this will improve quality possibly as much as having more NPs on board”*. Another point raised by a GP was concern over the number of NPs available and that they would like to see these *“expert nurses used for their expertise not the paper pushing*

*roles they are often pushed into*" and that overall, the general education in LTACFs for nursing staff needed to be increased. A GP who stated that they had previously worked with an NP was *"happy overall with the level of competency"*.

Table 4

*Participant responses to utilisation and view of NP role*

Utilisation/View of NP role	Response (%)									
	No problems at all		Very few problems		Some problems		Many problems		<i>n</i>	
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP
Patients' acceptance of NP	28.6	23.8	42.9	57.1	25.7	14.3	2.9	4.8	70	21
Doctors' acceptance of a NP	18.8	19.0	37.7	38.1	42.0	38.1	1.4	4.8	69	21
Nurses' acceptance of a NP	38.9	9.5	43.1	52.4	16.7	23.8	1.4	14.3	72	21
Quality of services rendered	40.8	28.6	42.3	52.4	15.5	14.3	1.4	4.8	71	21
Legal problems (licensure, malpractice etc)	34.8	14.3	39.1	66.7	23.2	14.3	2.9	4.8	69	21
Interference with doctor-patient relationship	26.8	19.0	43.7	52.4	26.8	9.5	2.8	19.0	71	21
Availability of funds to cover NP services	7.4	14.3	22.1	0.0	54.4	57.1	16.2	28.6	68	21

Utilisation/View of NP role	Response (%)									
	No problems at all		Very few problems		Some problems		Many problems		<i>n</i>	
	RN	GP	RN	GP	RN	GP	RN	GP	RN	GP
Demands on doctor time for supervision and/or consultation with a NP	14.3	9.1	45.7	36.4	32.9	50.0	7.1	4.5	70	22

<sup>a</sup> The count of skipped number of responses includes discarded data. Discarded data included in Appendix 4.

#### 4.2.4. Summary of the surveys

The surveys gathered data that identified the demographics of the participants, their current workload and their overall perception of the NP role. The following themes have emerged from the survey and warrant further discussion:

- challenging and unmanageable workloads
- reduced availability of GPs
- lack of experience, skill, knowledge base, and professional development opportunities for RNs
- communication issues
- concern over the division of labour between the NP and the GP
- acknowledgement that aged care is a specialist area requiring specialists
- the use of the NP can lighten the load of the GP and provide faster access to resident review, potentially reducing the risk of the resident becoming further unwell and unnecessary admissions to the ED
- the idea that the NP role should work in collaboration with the GP role

### 4.3 Interviews

In this next section, the themes from the interviews that were undertaken are described. Participants from the survey were invited to participate in one-on-one telephone interviews. A total of 20 RNs and 13 GPs consented to be interviewed, from whom seven RN and seven GP participants were interviewed. The final number of participants who were interviewed was decided upon when saturation of data were reached and no more new information was being identified. The professional experience of the participants interviewed ranged from 4 years to 50 years. The data gathered from the interviews were analysed using thematic analysis as discussed in the “research framework and methods” chapter. Interviews were recorded and the recordings were transcribed by the researcher. All interviews were coded so that no names or places were included in final analysis.

It is important to note that numerous themes emerged from the interviews. Because free flow of information was encouraged, respondents offered a diverse amount of information around the questions.

#### 4.3.1. Increasing complexity of residents and services offered

Participants from both groups were of the opinion that residents admitted into LTACFs were much more complex compared to when the participants first started working in aged care. An RN with 29 years of experience, with 26 years in aged care, commented that the residents' needs were now much higher, with the residents requiring more clinical care that needed more time needed by the RN in order to fully address those needs. Contributing factors linked to the complexity of the residents were the age of the residents and the number of co-morbidities. One RN noted that, in the past, residents were admitted into LTACFs prior to actually requiring much care, whereas today they were admitted older and at the stage where they needed significant clinical support. Furthermore, it was noted that skilled staff were needed to look after residents and perhaps *"people are becoming more aware of the difficulty of looking after this type of patient"* (Interview RN07).

An RN who had been nursing 52 years and who had worked in aged care for 32 years commented:

*"When I first started probably a lot of the residents were at more rest home level and we didn't have anyone that had challenging behaviours, was not kept in a facility like this. They were more in an institution. So the type of resident we look after has changed greatly"* (Interview RN06).

The RN further commented that the type of residents being admitted into LTACFs today used to stay in hospital and *"we now look after residents that are much more complicated than we ever looked after before"* (Interview RN06). This comment was supported by a GP, who recognised that the type of residents being admitted to LTACFs used to be kept in hospital to die and that these residents were being discharged earlier from the DHB sicker than they were 30 years ago. This GP identified an increase in the number of residents with dementia and because hospitals were discharging people earlier, this placed a higher burden on the palliative care requirement in the LTACFs, thus providing the greatest challenge for staff.

A GP whose sole work was in LTACFs stated that the acuity of the residents had changed with residents now being much more dependent on staff. The GP commented that it was not only residents in the hospital-level wings who were increasing in dependency but also the residents in the rest home, who in turn were also *"dependent on the hospital"*. The GP further stated that, in the past roughly 25% of the residents were admitted to LTACFs required

hospital-level care, whereas now this figure was approximately 50%. When asked what impacted on their time, one RN stated:

*“On the floor basically doing medication rounds, following up with doctors, doing transfers to maybe hospital, if there is a fall we have, that is quite time consuming. Managing if there are any challenging behaviours, they take more time to deal with. Also with the palliative residents they can require a lot of additional intervention to ensure that they are comfortable, managing pain and anxiety”* (Interview RN04).

An alternative viewpoint to whether residents were becoming more complex provided by a GP was that the types of residents in LTACFs have always been complex, but what has changed was the awareness of these complexities and the needs of the older adult population. The GP further commented that it was because of this increased awareness that the level of expectation had changed, in that higher standards of care needed to be provided and that the older adult had the same access to treatment that any other “sick” person would have. In a similar response, another GP said

*“Yes I think that to be absolutely fair we are all aware of the fact that as people are getting older and have a lot more medical problems and medical signs as extended life, things are more complex, people have a lot more medication, they have a lot more illnesses, we keep them alive for longer and the whole thing becomes a lot more complicated. So yes I think that care is more complex and I think that the problems are more complex and things are certainly not as simple as they were twenty years ago”* (Interview GP04).

The change in approach to treatment of the elderly was again raised by another GP, who described the change as there no longer being an “age defined limit to when you are going to get the good attention, now it is more based on what the quality of your life would be if we went ahead and did all that would that improve the quality of the patient’s life, would it, yes be a sensible thing to do rather than oh I am sorry you are 75 so you don’t go to hospital” (Interview GP02).

It was acknowledged by the participants that the increase in resident complexity, together with the increased awareness of the older adult needs and change in approach to treatment, did place increased pressure on RNs, GPs, and the hospital services. With the rise in the older adult population increasing the number of residents in LTACFs, a GP recognised the potential of the hospitals being only filled with people from LTACFs and the “learning curve

for everybody” (Interview GP02) regarding the need to balance using the hospital system and providing effective care for the residents in the LTACF.

The average number of co-morbidities per resident varied between participants from three up to 10. The most common co-morbidities identified by the participants, in order of prevalence, were dementia, strokes, diabetes (including amputation as a result of diabetes), heart failure, chronic obstructive pulmonary disease (COPD), heart disease, hypertension, respiratory conditions, cancer, musculoskeletal problems including osteoporosis and mobility impairment, sensory problems, and incontinence. The services offered by the LTACFs were continuous care at hospital-level, dementia care, rest home level care, palliative care, respite care, and convalescence care.

#### 4.3.2. Factors impacting on providing quality care to residents

The participants were asked to identify factors that they thought impacted on their providing quality care to residents. The themes that emerged are discussed next.

##### *Challenging Workloads and isolated and invisible role of RN*

A developing theme focused on the workload requirements of both groups with regards to the number of residents each RN was responsible for during their shift, the number of LTACFs each GP had as part of their workload as well as the number of patients they saw weekly in their practices, the paperwork requirements, the isolated role of the RN, and the complexity of the residents discussed previously. As stated by an RN,

*“I mean when you think about it the RN working in aged care is actually fairly isolated. They are responsible for a huge number of patients and they have actually then got to know what is happening in the rest home or what is happening in the dementia unit and what is happening if someone in the village decided to ring the emergency call cause they have fallen over or something like that. So they have actually got huge amounts of responsibility plus their normal workload in their hospital wing or unit that they are actually care for people in” (Interview RN01).*

The same RN identified the difficulty for RNs regarding the expectation that they were actively responsible for the whole facility, particularly after hours, and then were also expected to respond to an emergency. In most situations, it was noted that there usually was only one RN on duty for some facilities, and particularly after hours or weekends, and the RN also managed ENs and HCAs, which contributed to their workload. An RN stated that, during times when they had been short staffed, a second RN had been put on duty. From the RN's feedback, this was greatly appreciated because they felt supported and could discuss

challenging aspects of care with each other. An experienced RN commented that the size of the hospital-level wing and the number of beds (above 30 beds) was too much for one RN to manage, especially the less experienced RNs. The RN acknowledged that the less experienced RNs did have support from the more experienced RNs who were covering different areas on their shift but was of the opinion that the support was *“not quite as it should be”* (Interview RN05) and the number of residents they were expected to oversee was challenging.

The common requests GP were called for were to prescribe per oral antibiotics (POAB) for residents considered to have an infection, to complete paperwork, or to chart/change medications. The number of patients the GPs stated they saw weekly ranged from 30-100, including the residents from LTACFs.

#### Staffing Levels and Unregistered Workforce

Staffing levels were identified as impacting on the care provided to residents, in particular, staff-to-resident ratios and the use of unregistered health care workers, for whose practice the RN was expected to take accountability. It was estimated that each HCA had five to seven residents and it was also mentioned that not all HCAs were rostered to work the full shift. Some HCAs, for example, would work until 1230hrs, which reduced the number of staff after lunch time. An RN stated that people with a high dependency required more work, therefore requiring more staff; at times this need was not always possible to fulfil. Furthermore, when staff did ring in sick, particularly after hours, it was left to the RN on duty to find a replacement, which potentially was time consuming.

*“Usually the issue with being short staffed, not being able to replace key staff on the floor and I get called in at pretty short notice with limited casual staff to be able to replace them”* (Interview RN04).

*“last night I spent three quarters of an hour trying to sort out staffing issues for the night and the next day so that is an extra task which cause you are the duty leader you take that on”* (Interview RN05).

The importance of educating and supporting the HCAs was highlighted. Due to the nature of the work, RNs and GPs were often relying on HCAs to know what they were looking for, to identify issues, and to report these accordingly. A task such as emptying a catheter bag and recording/reporting the urine output might be a task that an RN expected an HCA to undertake. However, as pointed out by an RN, one cannot assume that others follow practice. The RN described a situation when an HCA, with 22 years of experience, had been recording

*“really good urine output”* in the previous week (Interview RN03). When the RN stood with the HCA, the RN was surprised to see that the HCA recorded the urine in an indwelling catheter (IDC) bag by standing next to the bed and just looking at it, rather than using a measuring jug. A GP commented that sometimes an HCA, or the manager, who was not medically trained, would request a resident to be reviewed based on what they believed to be wrong with the resident and *“sometimes makes errors”* (Interview GP01), which can cause anxiety for the resident and their family. The GP further stated *“when you have unqualified people that is a problem”* (Interview GP01). This comment was reinforced by another GP who stated that due to cost, LTACFs tended to not

*“have a lot of Registered Nurses and they tend to have just enough Registered Nurses to do the jobs that are required and they have other staff for them to deputise to, I guess. But that puts a lot of pressure on the RNs to maintain the quality of the care, the medical care. I see that as being quite stressful for them too, another issue”* (Interview GP02).

Some LTACFs are encouraging their HCAs to complete further training and gain qualifications through the Aged Care Education (ACE<sup>14</sup>) qualification programme.

An RN with less than five years of experience stated:

*“When we are short staffed, recently we were expected to have a team as well as our daily duties however it was a bit unrealistic”* (Interview RN04).

#### Paperwork Overload

Another factor identified as adding to the participants' workload was the paperwork requirements, in keeping with the mandatory audit and reporting requirements referred to previously in the survey data. The more experienced RNs identified a change in the amount of paperwork over the years and how this change was linked to an increase in accountability and responsibility, with two commenting

*“there is a tremendous work of documentation now. So that is one of the very great differences between when I started here and now”* (Interview RN05).

*“huge change in accountability and documentation”* (Interview RN06).

The second RN linked the change in accountability and documentation to the Health and Disability Standards being implemented, which was not the case in the past.

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<sup>14</sup> The ACE programme provides HCAs with the skills and knowledge they need such as completing personal cares, observation, reporting and documentation, manual handling, and infection control (Health ED Trust New Zealand Inc, 2014).

From the GPs' point of view, paperwork increased their workload because sometimes they were contacted to complete paperwork such as changing a review date on a medication chart. As stated by GPs

*"I don't know if it is just residential aged care all the different things they have to do like everything has to be signed off, you know by the doctor every so often"* (Interview GP01).

*"the Thursday afternoon and especially Friday the whole day you would have one hundred faxes about somebody who had, some charge nurse looking at the weekend, they noticed some things are, or there were issues outstanding that needed, some sort of thing and I would get thousands of things, of faxes coming through and things to be done, forms to be filled out, medication sheets to be redone and all that kind of thing, three monthly visits and you would need to urgently do three monthly visits and all that stuff, that all happened on like a Friday and would be awful"* (Interview GP07).

A GP commented that the assessment required to be completed by the RN would be *"overkill for me"* and that it could take up to 3 hours for the RN to complete one assessment, which the GP did not find very clinically useful. A GP who no longer provided care to LTACFs but often visited friends in them stated that the RNs attempt to do their best but

*"they have got a lot of clients to look after and sometimes just don't get around everything. They have got this huge load of admin work and paperwork that has to be filled out and audited and looked at and at the end of the day all that is done and the patients get left...this whole trend seems to be getting worse and I know that all of us in health care, and I talk to people in education as well, they will tell you about the battle of the paperwork we fight"* (Interview GP04).

This comment was maintained by another GP, who said that the auditing had contributed to improving the quality of services delivered in LTACFs and also made them more responsible; however, the GP said that *"there are some aspects of it that I think are quite onerous. It is mostly in the area of documentation"* (Interview GP06).

#### *A young nursing workforce and lack of clinical skills*

Some GPs were of the opinion that the less experienced RNs (the number of whom appeared to be increasing) added to the GPs' workload because the RNs looked to the GPs to provide support. As stated by two GPs

*"I feel sometimes that the doctor seems to be contacted for what is an inferior reason...sometimes I don't know whether it is the rules or they don't seem to be able to take much initiative on something that would seem obvious...I would have thought a registered nurse that worked in an aged care facility should have had the ability to make that decision"* (Interview GP01).

*"You get more confidence in what they say than some of the others that get anxious and feel much more secure if they ask for a medical assessment. Then that is all medical professionals isn't it? When you are young and you don't know a lot or when you are anxious that you might miss something you tend to use the services more than you do perhaps when you are more confident"* (Interview GP02).

This comment was confirmed by an RN, who commented that the natural reaction of the less experienced RNs was to *"call for help"* and that these RNs needed to be reminded that *"they are actually the ones that are supposed to be providing the help"* (Interview RN01). Often the RNs in these situations were considered less experienced (0-5 years of experience) or came from areas of practice where they had more experienced RNs and medical staff on hand, such as the hospital environment. With the increase in newly experienced RNs, an RN commented that they had needed to employ RNs who were new graduates or who had less than 5 years of experience because *"there are not a lot of older RNs who are looking for work in aged care"* (Interview RN01). An RN stated that they had a 'House GP' who did regular ward rounds twice a week. The RN found that the use of the GP's time was not always appropriate and that the RNs were often looking to the GP for a medical intervention before they considered a nursing intervention. This comment was made in relation to an Internationally Qualified Nurse (IQN). This need to look for a medical intervention caused more residents to be added to the GP's list than actually needed to be there, which at times overwhelmed the GP. Another RN stated that *"I have had to come in at times and that is absolutely fine because with our younger RNs and the concerns that they have I would come in yes. They have got to be supported"* (Interview RN03).

In addition to a high workload related to staffing, all the participants who were interviewed stated that they worked more than their required 8 hours a day. One RN commented that during her tea break she took the phone with her *"so I can filter any calls that might be incoming"* (Interview RN05) and that her experience had helped her co-ordinate the afternoon shift and complete her work on time. However, she did note that

*"in the younger less experienced people, they are putting in the extra time but it all depends on notes and things like that"* (Interview RN05).

A few GPs stated that, in some LTACFs, the staff turnover was quite high, which in turn increased the GPs' workload. Reasons given for the high staff turnover were management issues, staff feeling unsupported, and RNs initially being unaware of the difficulty and responsibility of the work and role. Also aged care could be seen as undesirable work by nurses. One GP stated that the high staff turnover added to their workload because the new staff *"put their best foot forward"* (Interview GP07) and, in particular, those staff who lacked experience would ask the GP to review residents with minor problems that perhaps a more experienced staff member could have managed and the GP ended up supporting, explaining to, and training the RNs. With reference to one particular LTACF, a GP stated that there were

*"not highly qualified staff so it became that you would be spending a lot of work there because they were all so inexperienced"* (Interview GP07).

This GP further stated that the inexperienced staff mostly impacted on the GP's workload with regards to paperwork requirements because they needed to continuously build relationships and would get faxes after work with paperwork requirements to complete.

It was identified through the interviews that aged care nursing was not considered "glamorous" by the nursing profession even though it was regarded as a role where skills and knowledge were paramount, especially considering the degree of autonomous practice in this area of nursing. Other comments that stood out from GPs were

*"have maybe slightly higher trained nursing staff they could do a little bit more, cause we can't do IVs and stuff and sometimes it would be actually quite nice to do a very short term IV on a patient and prevent them from going to hospital"* (Interview GP03).

*"Quality, well I guess it is, it is really from the manger down to the adequate staff, getting, connecting good caring staff, well looking after old people is not for everybody, people with good empathy and a special interest in old people. It is a bit more than caring for their medical conditions from coping with you know the physiological effects and their grief and loss and getting people along"* (Interview GP05).

*"I think that the experience of some of the residential care nurses, it is not a glamour part of nursing. So there can be some skills lapse in there which are a problem for residents and nurses in those facilities. Older nurses who have been out of nursing for a while whose skills are not maybe what they used to be, or younger nurses who are immigrants who are just starting in the country for whatever reason...So yes*

*cultural things and experience and experience and the nursing staff and it is not a glamour job being an aged residential care nurse when I think it is important but it is not seen that way by the nursing profession” (Interview GP06).*

A GP commented that to the high staff turnover and management issues in some facilities had led to the GP’s colleagues feeling unsupported in their role, which resulted in the potential for GPs to leave the facility.

Reference to IQNs were also made by other participants. Participants acknowledged that IQNs were *“very good at what they do”* (Interview RN07) but cultural differences and methods of training were raised by some participants, such as being very quick to seek medical input rather than approaching/managing a situation from a nursing perspective.

Regarding cultural differences, a GP stated:

*“Some of the cultural differences are a problem as well. For example nurses from other cultures particularly Asian cultures and Indian cultures have, they find it hard to deal with death and dying and for example they get upset. So they do everything they can to keep a person alive and feel that they much check everything, keep trying to do everything to keep them alive even when it is obvious they are in the end of life”* (Interview GP06).

One GP was favourable about IQNs, saying

*“they actually do a very good job, I like them a lot. Yes, they have given me a lot of support; they do what I say, good feedback, kind to the patients, goods empathy and so on”* (Interview GP05).

Regarding aged care being seen as “unglamorous” among nurses, inexperienced nurses, and IQNs, one RN stated:

*“It is still not the popular place of choice and I know that because we have had over the last five years new grads coming as part of the NETP programme and they really only come because they can’t get a job anywhere else. We have the very odd one that chooses to work here by choice and we have a huge amount of overseas people who come in and start with us, get the experience and then leave for the DHB”* (Interview RN06).

#### Availability of GP to review residents

There was a difference among participants regarding the availability of the GP to review residents when requested by the RNs. GPs who had regular ward days and GPs who

were the House GPs with the LTACFs identified that those facilities took up less of their time compared to facilities where they did not have a regular ward round. Reasons given for these differences were that, in the ward round situation, they were able to build a relationship with the staff and be involved with the day-to-day management of care of the residents. They could pre-empt situations arising.

*“Our first GP day is Tuesday and the second one is a Friday so we have got our most experienced GP comes in on a Friday so he makes sure that anything is out is in place for the weekend. Then if someone is deteriorating or becoming palliative he comes in for the emergency stuff and then on the Tuesday often the Tuesday GP is often doing follow up stuff or the three monthly medical checks or the monthly medical checks depending on how well someone is”* (Interview RN01).

When asked what factors impact on delivering quality care to residents, a GP who at the time employed an NP stated:

*“Well I think availability is a big one. It is you know being available when the need arises. For someone to actually turn up you know. So availability is a big one, I do hear a lot of second hand from Registered Nurses in the residential care that GPs just don't come or they don't come for a week or they don't come for two weeks or, they are hard to get hold of or the service is not very responsive. So don't like hearing those stories and I think the way that we have organised it is that we don't have that problem really. With the NP we have an extra set of hands to, and extra brain to provide, to actually attend in a timely manner”* (Interview GP06).

A GP stated that if an RN contacted the GP clinic requesting a non-urgent resident be reviewed, they were usually able to see the resident the same day because they had a system whereby a GP was available to attend to these calls. The GP commented that this sort of system prevented a resident deteriorating unnecessarily. Having said this, the GP recognised that not all practices are able to provide this level of support because of cost. If a practice had a GP who was available to visit LTACFs when required, then the same GP might not be seeing patients in the practice and therefore might not be earning money. Furthermore, the GP commented that many of the requests from the LTACFs did not require the GP actually needing to go to the facility, such as changing medication, but stated that if a GP was required to go to the facility, then they should be able to go. Alongside the issue of *“no facility for the practice to absorb extra requests for assessments”* (Interview GP02), the GP noted that all the GP's time was allocated and, at times, might be *“overbooked”* and *“too busy”*, reducing their ability to *“have any leeway”* and resulting in the GP

*“either having to do them in your lunch hour or before you go to work or after you finish work or you delay it until you can make time. All those options are not as good I don't think as a system that can accommodate those visits on the day...But of course that ends up costing the practice money...so that means that they system is not quite so cost effective as far as making money for the surgery goes. It may well be far better for the patient because of course then they don't get so unwell waiting to see us” (Interview GP02).*

One RN stated they had two House GPs and the LTACF also had access to their local medical centre. With regards to non-urgent residents, the RN stated that sometimes, during the day or after work, the GP would review the resident, but the medical centre usually requested the resident be sent to them, which was not always convenient. This use of the ambulance was the same for the review of urgent residents, whereby the practice would request the residents be sent to the outpatients department. During these situations, the RN said that the resident would either be sent in an ambulance or be accompanied by staff or a family member. The RN further commented, *“generally if we want the doctor we don't want them seen down in the clinic”* and *“it's not good for them to sit there for hours waiting to be seen”* (Interview RN07). Having dedicated GPs and GPs who were more available to spend time with the RNs, listening to concerns and discussing alternatives to issues, is a factor that the RN said might improve access to care for residents in LTACFs. The RN further commented that spending time with the GP was also a way for RNs to learn. Another RN whose LTACFs did not have a House GP stated:

*“we have residents who are quite acutely unwell where doctors you know decline to come and see a patient, or you know there have been times when patients issues have not been addressed as soon as what they should be”* (Interview RN04).

When asked what the timeframes for GP visits were the RN further stated:

*“Well depending on each situation it is variable, generally if we can reach a doctor and we can send through all the information and give a description and their drug charts that they may come back with something prescribed or a referral say if they have got something systematic and they need antibiotics but sometimes where people are acutely unwell they need hospital treatment and they are uncomfortable and we have had doctors that haven't come, who have refused to come”* (Interview RN04).

An RN from an LTACF that only had House GPs said that their GPs were responsive and would come either in the morning or at the end of the day.

### Cost to care

The issue of lack of funding and financial constraints was a common theme among many of the participants. The lack of funding related to

- short staffing
- assessment criteria of residents between rest home level care and hospital-level care
- having just enough RNs
- not paying RNs to complete basic cares
- pay disparity between LTACFs and DHBs
- lack of resources and access to other services
- not paying GPs for all their services

The pay disparity between the LTACFs and DHBs was noted by one RN, who commented that an HCA could earn more money watching a patient in the DHB than they did completing the demanding workload in an LTACF. The higher pay rate of the RN in the DHB was also mentioned.

Difficulty with “fitting” residents into the assessment criteria was mentioned by some participants. It was noted that when the resident was unwell in the DHB and needed to be discharged to hospital-level care in an LTACF, the DHB was granted funding for this resident to receive these services. The issue with the funding for LTACFs was that it was only for a limited duration and when the timeframe was near completion, the participants stated they needed to reapply for the funding. The participants commented it was difficult at times to get the funding, especially if the resident was deemed to be recovering. In these instances, they would only receive funding for rest-home-level care and when the resident began to deteriorate again, they would need to reapply for further funding, which at times the approval might be delayed. The other issue raised was a participant stated she was contacted by the DHB and asked if they had a hospital-level bed for a resident requiring this level of care who had dementia. Two weeks after the admission of the resident, it became apparent that the resident was not actually assessed at hospital-level care and that the shortfall of the funding was being topped up by the dementia-level, which was due to end soon. As it was apparent

to the LTACF that this resident would be unable to return to dementia-level care, the staff needed to apply for the appropriate funding, which the RN stated should have been done at the DHB.

In relation to not paying RNs to complete basic cares, one RN commented

*"Oh sure I mean we have to have highly qualified and paid staff, well I mean you have got to train our care givers to give us that care. We can't consider, certainly can't afford to have the nurses doing it and the Registered Nurses don't want to do it, a lot of Registered Nurses don't want to do the care that is necessary unless there is cancers"* (Interview RN07).

One facility had access to a gerontology Clinical Nurse Specialist (CNS) who provided the RNs at the facility with education. The RNs were able to ring the CNS for advice, but, due to budget cuts at the DHB, the brief of the CNS changed and the CNS is no longer available to do the education. The RN stated this was a real shame because the education benefited the RNs and was something that was valuable to aged care in general.

Regarding staffing and doing extras for residents, cost and funding were identified as issues. A GP stated that they were only paid to look after the person during the day and therefore the GP was unavailable after hours. A GP who was contracted to an LTACF for 2 days a week stated that they were *"very stringent"* (Interview GP03) about keeping to contracted time because the LTACF had no money to pay the GP for extra time unless a resident had an acute event. The GP further commented

*"But there is no funding, it all depends on funding but I presume the nursing home really gets relatively little funding for the complexity of their clients. They have to then divide up into different options, medical care is unfortunately not usually high on their priority list"* (Interview GP03).

In relation to the RN deciding to send a resident to ED, it was acknowledged by the participants that this might occur. One GP thought it might occur often and stated that this could be due to the RN struggling to access a GP to review the resident because the GP was too busy at the practice and/or the GP *"is not going to be properly remunerated to actually go and see that patient then you know it makes sense for the RN to make that decision"* (Interview GP03).

A GP who previously provided services to LTACFs stated that they stopped providing services to the LTACFs because of all the added stress, not being paid for all the hours given to the facilities, and the amount of administration work required. Since retiring their services

from the facilities, the GP stated they could now concentrate on developing their practice and their own patients.

During these interviews, it was noted that the GPs were very clear about not doing extras because they would not be remunerated for it. The RNs, on the other hand, did not mention remuneration even when they discussed the reasons for working more than their paid 8 hours. More discussion on this difference will occur in the next chapter.

#### Absence of after hour services

A common theme was the absence of after hour services to the LTACFs. Some facilities that had a house GP and regular GP days were fortunate to have access to their GPs fulltime. For other facilities, this was not the case and the RNs had to either try and make the resident comfortable over night or send the resident to the ED for care. Some GP practices had a contract between the practice and ED to cover the facilities overnight but this was not the same for all the facilities. For the facilities that did have set GP days, the GPs and RNs would try to anticipate situations for residents and plan for these, especially before the weekend, with a review after the weekend. In the facilities that did have access to their GPs after hours, the RNs were asked to contact the CNM or the facility manager prior to ringing the GP. They were asked to do this to ensure that a GP did need to be contacted overnight. One GP whose practice did provide an overnight service stated:

*“So I think also I mean we are, the way our service works, it not ideal you know because it is I mean for old aged care generally patients will come to a surgery where they could be out of hours they need to actually go there it is far more expensive, so you know I think the cost to business is huge for patients after hours. And so for them, from a home point of view, it is cheaper for them to send somebody in to ED then to actually ask us to come and see [them]” (Interview GP03).*

In a facility that did not have access to GPs after 20:00 hours, the RN commented that they tried to plan for everything but that this was not always possible. They had access to an RN at a call centre in a different region after hours but, as stated by the RN, this *“is not what you need, what you need is a doctor”* (Interview RN02). Another RN stated that they had access to a GP until 17:00 hours and if issues remained unresolved, for example with palliative care residents, then the option might be to send the resident to hospital. The RN stated that the feedback they received from the ED could be negative, particularly for residents receiving palliative care treatment. The RN commented that it could be difficult after hours to know what to do when you had a resident who was uncomfortable and in pain and

the only access you had was the ED. This comment was supported by another RN who stated that if they did not have PRN medication prescribed and the resident was in significant pain then, they would call for an ambulance. The RN further discussed that *“the hospital do sometimes give us a hard time for sending someone to them that we think needs to be there but they decide that they don’t think they should. There is that fine line (Interview RN01)”*.

Another RN participant commented that it was rare to need to send someone to hospital and stated:

*“...it is not quite the feeling now that it is okay for an old person to gently decline in place, you know there is a little more discussion to whether that person should be hospitalised. But I do tend to feel that we are their last port of call and we should look after them properly” (Interview RN05).*

The RN expressed the importance of the Enduring Power of Attorney (EPOA) and the need to have a discussion with the resident, family, and GP around aspects of care, such as active treatment and not-for-resuscitation (NFR).

A GP aware of the difficulties for LTACFs to access medical care after hours stated that the ambulance did get called and the resident was sent to hospital. The GP continued to say that issues of health, such as a UTI, did not get seen as an emergency, so they tended to leave the resident for the weekend, which resulted in the resident becoming uncomfortable. The GP further commented

*“Then the other issues, my impression of some residential aged care facilities is that the nursing staff are very busy complying with all the paperwork and the admin that needs to be done and they are filling in forms and ticking boxes when actual patient care is not, does not appear to be priority number one” (Interview GP04).*

One GP highlighted the fact that access to a GP 24 hours a day 7 days a week did not happen anymore and that it was more the older GPs who provided this service. The GP stated that *“Things are changing, a lot of GPs are now only available Monday to Friday 08:00am to 05:00pm” (Interview GP04).*

#### *Absence of shared communication systems and poor access to field experts*

A theme that emerged from the GP interviews was the lack of a shared communication/computer system in the LTACF and the GPs’ practice. The issues centred on concerns that potential mistakes would be made in transcribing twice at two different locations (i.e. the GP documents in the LTACF’s hardcopy file and then the need to document in their

electronic notes at the practice), the GP opting to enter all their residents onto their electronic system but this task needing to be completed in their own time and without payment, and lastly, GPs opting not to document back at the practice due to not being paid for it.

*“to be honest I have now computerised every patient, that has been in my own spare time so I think I mean, most of the time they think I am completely mad spending my own time doing that but it has helped me in the long run but I think that is why most GPs, because I spoke to quite a few, they are not doing it because I presume it is very time consuming and you don't get remunerated for it so they are not going to do it” (Interview GP03).*

Access to a shared computer system was highlighted as being efficient and reducing the potential for mistakes. A GP stated that following the current process of writing notes in the facility and then needing to redo this at their practice could take up to an hour per patient.

Another central theme was the desire to have better communication, and perhaps shared ward rounding, with experts such as gerontologists, CNS, and NPs from the DHB. A GP stated that it would be beneficial for them to meet with the geriatrician and discuss *“protocols, guidelines and what they would like and would prevent for example a lot of unnecessary admissions”* (Interview GP03). This comment was supported by another GP, who said that it was difficult to arrange ward rounds with the geriatrician or other services because of being unable to leave the practice during the day. The GP stated that because the routine of GP hours was not similar to the routine of the Specialist hours, no effort was made to liaise with the GP. The GP highlighted the fact that often GPs were expected to pick up patients in the community and were therefore expected to know everything, including geriatrics, which was unrealistic and difficult. The GP stated that geriatrics is a specialised area requiring specialist input. The GP further commented that staff working in LTACFs themselves did not always have the knowledge of geriatrics and would look to the GP to provide that guidance.

One RN stated that there could be better communication between the DHB and the LTACF. The RN commented that sometimes they did not receive all the information they needed from the DHB, which required a lot of their own time trying to retrieve all this information from the DHB. Since working with the CNS at the DHB, the RN stated it had improved as the CNS was able to liaise between the wards and the facility about what was required. Furthermore, it was acknowledged that the CNS also educated ward staff regarding what resources the LTACFs actually had access to, which reduced the number of residents being discharged with plans that might be difficult for the facility to meet.

### 4.3.3. Ways to improve access of care to residents in LTACFS

#### Higher trained staff and increased skill mix

Another theme raised by a GP to improve access of care for residents was to have RNs who had more training and were able to complete more aspects of care, such as administering IV medication. The GP stated that if the RNs were able to do this, then alternative treatments could be given to patients without them necessarily needing to go to hospital. This, in turn, might reduce avoidable hospital admissions. The GP also acknowledged the requirement for RNs to maintain their competencies and suggested this might be an issue if they did not have enough opportunities to maintain their skills. The other issues raised by the GP was who would fund the RNs to maintain their competencies in this area as LTACFs already had funding issues.

Another GP stated that aged care needed people who had the knowledge to provide proper care and that *"...I think the staff at the facilities need to be trained especially, or need more extra training and further qualification in that area to do the job properly"* (Interview GP07).

#### NP role

All the participants interviewed were favourable to the NP role being established in aged care. Those who had not had experience with an NP saw the role working best in collaboration with the GP. The GPs who did have experience working with the NP were more comfortable with the NP working independently but were also happy to support the NP, should they require someone to discuss issues with.

The RNs identified the NP role as a model of care that could be beneficial to aged care. The RNs saw the NP role as providing education to RNs, enabling a more accessible and therefore faster review of residents preventing unnecessary deterioration of the residents, providing an extra set of eyes/observation that would pick up aspects of patient care/concerns missed by the RN, easing the load of the GP, providing support for the RNs and the GPs, and being a 'go to' person to discuss concerns about residents. Providing education to the RNs was an aspect of the NP role that RNs stated they would find beneficial. One RN commented that the NP providing the RNs with education would improve the performance of the RN and *"help the residents in the long term"* (Interview RN01). An RN stated that, especially at times when the RNs were unsure if they should send a resident to hospital, the NP would be a valuable source to consult with.

One RN commented:

*“Just cause sometimes you do sort of go along and you do have to think outside the square and maybe if you had an afternoon a week or something with the Nurse Practitioner that would be a real help. You could bounce ideas off and behaviour things” (Interview RN03).*

An RN who had experience with an NP said they were able to access an NP when they were unable to access the GP. The NP had experience with older persons' health and the RN found the NP *“amazing”* (Interview RN04). The RN stated that the NP liaised and communicated with the GP at a much more advanced level than the RN could and that the NP implemented a plan for the resident.

One RN who did think there was a place for NPs in aged care stated that it was dependent on finding the *“right person”* (Interview RN07) who needed to work with the RNs. This RN stated that, currently, they were working with an NP who was training and found that, so far, it was *“a waste of time”* (Interview RN07) because when they contacted the NP, the NP would need to discuss it with the GP, and then visit the facility. The RN thought it would be easier if they dealt directly with the doctor. However, the RN acknowledged that the NP was not trained yet and perhaps it would be a different story with a registered NP.

The GPs saw the NP role as having the ability to lighten their load, being more readily available to see to residents, and preventing unnecessary deterioration. The role of caring for patients was seen as being shared by the GP and NP, and for those GPs who did have set GP days, the NP could do some of those days and also do common disease management. Other aspects of the role were that the quality of information received by an NP would be advanced, which in turn would be beneficial to the resident. Some GPs saw the NP completing the 3 monthly visits and managing routine issues. In response to how an NP could support the GP, a GP commented

*“I mean I think we have to face the fact, I know from colleagues of mine who work in aged care facilities that some of them are, felt that the job is overwhelming because they do a lot of patients and have very little time to do them and they rely too much on the nursing staff in the facilities to prioritise and adequately triage and see what the problems are. The doctor will be going in for only a couple of hours and there is a limit to how many people you can see in a couple of hours. So you rely very heavily on very good nursing staff and if you don't have that in the nursing staff that is when it becomes a job that is really too hard” (Interview GP04).*

The funding of the NP role remained complex. It was highlighted that a GP practice hiring an NP could be costly. The majority of participants saw the funding of the NP role being shared between the DHB, the PHO, and the Aged Care Provider because it was acknowledged that the health of a resident impacted on all three sectors. One GP referred to this sharing as *“transboundary care”* and stated:

*“this is not obviously a primary care problem, these are secondary care problems as well. I think the hospital could save millions most probably with all these unnecessary admissions if they joined in the whole process”* (Interview GP03).

Another aspect of the NP role that was seen as beneficial was their expertise in older adult health. A GP who had experience working with an NP questioned why the NP role could not work independently in the aged care sector and understood that the use of the terms *“general”* and *“nurse”* were going to be obsolete and that soon both would be referred to as practitioner. The GP stated:

*“Where I think that if she is trained, a trained Nurse Practitioner in gerontology that has a diploma or certificate in gerontology would be far better trained than any GP to do that work if they are doing it day to day. Because like anything else you have to do it day to day, you have to be in it to get the most out of it”* (Interview GP07).

The GP further discussed how their colleagues were initially unsupportive of the NP role but had seen the benefits of the NP. The GP highlighted the decreasing GP numbers in NZ and stated:

*“the GP workforce survey would say that there would be probably 60% less GPs around and in fifteen years’ time less GPs around so we have still got more than half the GP population that will not exist anymore and if you don’t have that many GPs despite what anybody is telling you who is going to take their place?”* (Interview GP07).

Another GP who currently employed the services of an NP, whose scope of practice was older adults, stated that the NP was undertaking set GP day visits to the facilities and that so far this arrangement was working well. As the NP was an employee of the practice, the GP saw the role as working in collaboration. The GP stated that the role of the NP had grown and that the NP was now visiting other facilities. The GP commented that the NP prescribed independently and that if the NP had concerns about anyone after completing the visits, the GP and the NP would meet and discuss these concerns.

A concern from some participants was the availability of the NP to cover after hours as one GP commented *"The point always remains you know it is, you should really have 24 hour care and that just means you can't do that with one Nurse Practitioner you need several. People are not ill in office hours"* (Interview GP03). A GP saw the NP role as *"improving things in aged care facilities"* and that more NPs were needed in the community and rest homes to be the *"go between and the liaison between caregivers and doctors"* (Interview GP04).

#### **4.3.4. Conclusion**

This chapter discussed the results received from the survey and interview data. Whilst there has been a focus on the workload, staffing and complexity of patients, these are the themes that respondents referred to as influencing their ability to manage care. Whilst these themes left the researcher wondering what significance the themes had on the perception of the employment or use of NPs and their effectiveness in an aged care situation, the significance of the gaps identified by the respondents in caring for the residents lent itself to the overall perception that a review and reflection on the division of labour that was utilised and the way care is funded was needed in the residential facilities.

The participants believed that NPs could support care provision but were unsure of what exactly their role or scope would be came through in the surveys and the interviews, with concern over what authority they would have in that care, and how this would be managed within the current workforce and funding arrangements. There was clear uncertainty about the role, but the participants had a supportive view of their potential contribution to the aged care setting. The next chapter will discuss these findings.

## CHAPTER 5

### Discussion

The intention of this research was to explore the perceptions of RNs and GPs regarding NP-led care in LTACFs in NZ. As explained in Chapter 1, this research originated from the author's experience of working in an LTACF in NZ. During this experience, the author experienced the issues that faced the aged care sector and the challenge of working with these issues whilst trying to deliver timely, quality, and safe care to residents living in these facilities. One of the major issues facing the aged care sector today is trying to meet the demands of a changing population by using the same traditional model of care that uses HCAs, RNs, and GPs. The literature identifies an increase in the older adult population. People are living longer, resulting in more complex, acute, challenging, and increasingly dependent people being admitted into LTACFs. This research has found that the residents who are now residing in LTACFs would not have been admitted to the facilities in the past and that the number of GPs in NZ is declining.

To understand the two cohorts (RN and GP) and the challenges they face, questions around demographics, workload, and professional development were asked. The author believed that these questions provided background and were pertinent to understanding the factors that may influence the perception of the NP role in aged care. Discussion around workloads, skill levels, communication issues, and availability of the RNs and GPs will be discussed in this chapter. This research has demonstrated that the issues facing aged care are far wider than originally anticipated. The author did not anticipate the large amount of data this research would invite, and therefore, it is acknowledged that the extent of the data gathered has gone beyond the scope of a 60 credit thesis. Therefore, not all the data gathered have been discussed.

The intention of this chapter is to discuss the findings of the previous chapter. It is through the discussion of workloads, identified risk aversion, and workplace mandates that the participants have revealed the impact these have on their ability to carry out their work of caring for the elderly for whom they are responsible. It is through these data that it became apparent that the relevant features demonstrate how the respondents viewed the NP role in aged care. This research has raised far larger issues than the original perceptions of the NP role by identifying concerns around the current division of labour that is presently being used to manage the care of the elderly. The current unmanageable workload is further restricted by an environment that is time limited, appears to be risk adverse, and focused on budget rather than residents' needs. From this research, it is clear that somehow a balance between

managing risk and redirecting focus to the people needs to be found, maintaining the reason residents are there in the first place, whilst finding ways to limit the issues funding creates for this sector.

CST has been used to inform this research because CST allows for a wide range of data access to support analysis. It also enables insight into how people think, act, and respond to real life situations. With the literature review, CST allows for alternative sources of literature to support or contest the points under analysis (Cresswell, 1998; van Dijk, 2004). To understand the RNs and GPs perceptions of the NP role in aged care, factors that may influence these perceptions also need to be identified and explored because these allow for a more in-depth explanation as to how these two cohorts view the NP role. Therefore, the perceptions of NPs in LTACFs and the factors that may influence the participants' perceptions of the NP will be discussed in this chapter.

### **5.1. Challenging and unmanageable workloads**

Challenging and unmanageable workloads were a common theme among the participants. The following aspects were identified as influencing the workload: number of residents and patients, complexity and dependency of the residents, short staffing, unregulated HCAs, paperwork, services offered by the LTACF, and communication. Determining workload levels is important because it has been identified that the demands placed on those who provide care for older adults have intensified, and that it is this intensification that impacts on the overall wellbeing of those who provide this care (Kubicek, Christian & Heike, 2012). Therefore, the quality of care that is delivered to residents can be affected by the intense and stressful workload levels. As this research and the literature show, the older adult population is increasing, becoming more complex and dependent, which is placing greater pressure on the RNs, GPs, and secondary/tertiary services to meet these demands. RNs and GPs may find it difficult to meet these new workload challenges, which may result in gaps of care between the needs of the residents and the actual ability of the RNs and GPs to meet these needs. Identifying and acknowledging these gaps in care may influence how these two cohorts perceive the NP role in aged care.

As per the data, the general workload of the RNs encompassed a multitude of tasks, such as overseeing the care and wellbeing of a high number of residents, supervising unregulated HCAs, and being able to respond in an emergency and to complete other tasks and functions such as mandated paperwork requirements. It was identified that the role of the RN was often isolated from other health services and that the RN often worked alone, particularly after hours. The amount of work expected to be completed and the level of

responsibility the RN carries in a duty did not always match the confidence or experience level of the RNs as shown in the Results chapter. The data from the interviews also showed that it was not always possible for the RN to complete the workload requirements during their duty because the majority of the RN cohort stated that they worked more than their rostered hours. The complexity and dependency of the residents were also identified as influencing the RNs' workload because these residents required more time and more clinical input. The overall role of the NP was viewed as highly favourable by the RNs in reference to the NP being a support for the RNs. The RNs also wanted to use the extended practice and advanced knowledge of the NP to discuss complex issues, to pick up issues of care missed by the RNs' assessment, and to implement interventions in a timelier manner, in order to avoid unnecessary deterioration of the residents. As Stein-Parbury (2012) suggests, this need to meet care needs demonstrates "an attitude of 'being for' patients is how nurses demonstrate they care" (p. 5). This attitude was demonstrated by Carryer et al's. (2010) who showed that, despite the difficult circumstances RNs were often expected to work in, RNs remain committed to providing care. This committed approach results in moral conflict for the RN because they are unable to provide the quality of care they perceive their resident to need contributing to job dissatisfaction (Carryer et al., 2010). Low RN morale and job dissatisfaction were noted by Tukett et al. (2009) and was also linked to inability to meet resident needs and "inadequate numbers of insufficiently educated staff" (p. 2608). In relation to the NP role, Peri et al. (2013) showed that the NP decreased staff anxiety and increased staff confidence.

The GPs were in a similar situation regarding the high number of patients whom they see each week whilst being expected to respond to the aged care sector as well. The following factors were highlighted as contributing to the GPs' workload: the increasing complexity of the residents who were also becoming more dependent on care, no longer having an aged defined limit to receiving active treatment, funding issues, paperwork, and disparity of experience of the RNs in LTACFs. It was acknowledged by the majority of participants interviewed that the types of residents being admitted into LTACFs today are far more complex, with multiple co-morbidities, compared to the types of residents cared for in the hospital setting in the past. Furthermore, it was identified by the GPs that active treatment is now considered an option for everyone, regardless of age. This level of management has a domino effect on the secondary and tertiary services because people become sicker rather than just exhibiting the fragility of old age. Pruchno and Smyer (2007) make reference to the longer life expectancies and the impact on health care in terms of increasing cost and

demand. The concept that there is no longer an age-defined limit to receiving health care is an interesting one. Pruchno and Smyer (2007) describe the consequences of this well:

*“These age norms might shape the expectations of members of an aging society in two ways: first, an earlier disability or death might be considered “off time” and therefore might cause people to be less prepared for encountering the end of life; second, these age norms may well shape the expectations of family members and clinicians alike regarding a sick or dying person—and their assumptions about what is appropriate care and responsibility” (p. 3).*

Consequences of people living longer have resulted in ethical dilemmas that were previously unheard of (Pruchno & Smyer, 2007). In the past, a person’s autonomy would have decided the ongoing care to be given, where that autonomy was the ability to make conscious and rational decisions on what care to receive. With the advances of medicine increasing the life expectancy and resulting in people living with multiple co-morbidities, Pruchno and Smyer (2007) now say that the “ethical principles of autonomy, responsibility, and distributive justice will become both more salient and more interdependent” (p. 3). What this means now is that the person’s autonomy needs to be balanced against the family’s and society’s needs and/or wishes, as well (Pruchno & Smyer, 2007).

Another factor that was identified as impacting on the GPs providing care to this sector was time. Some participants commented that, given enough time the NP can make a difference to residents’ outcomes. Given the high numbers of patients GPs see each week in their practice, it was identified that all of the GPs’ time was booked for consults in the practice which only left the lunch breaks or early/end of the day available to review residents. This lack of available time made it difficult for the GPs to review urgent residents who were either sent to the hospital via ambulance or left until the GP was able to see them contributing potentially to the residents’ deterioration. In some cases, the GP requested the resident be sent to the practice via an ambulance, which may have been an attempt to reduce an admission to the hospital. However, this contributes to the increased cost of care that the resident may incur. The majority of GPs whose sole work was not LTACFs identified that it was difficult to leave the practice to see residents and that they were reluctant at times to do so because they were often not fully remunerated for their services. The GPs who used an NP to meet the needs of the aged care sector were favourable about the NP role and stated that they used the NP to review residents, undertake ward rounds, and complete 3 monthly reviews. The GPs who had experience working with an NP were less reluctant for the NP to work independently.

However, they still made time to meet with the NP to discuss issues the NP might have. The other option identified by a GP to meet the demands of aged care was to ensure a GP from the practice available to review residents when requested by the RN from an LTACF.

GPs whose sole work was LTACFs were less likely to report issues with providing care to this sector. They were able to be more involved with the residents' treatment and care plans, and did regular weekly ward rounds. The GPs who undertook weekly ward rounds appeared to have a more positive view towards the facility. From this, it can be shown that in order to meet the demands and needs of this complex population and to give care that is both of quality and timely, the GP needs to be fully involved in the care provided and to be able to have the time to do this. Carryer et al. (2010, p. 15) showed that the RNs identified as feeling "demeaned" by GPs who were unable to respond promptly to their requests to review residents. Also, being left to last, was perceived by the RNs as the GP "having a lack of interest". Peri et al's. (2013) study showed that the use of the NP in aged care reduced hospital admissions, attracted and retained the GPs because they felt supported by this advanced role. The study also found that residents were seen more quickly by the NP. This finding was supported by an RN participant who referred to the use of the NP to review a resident who required analgesia when the GP was unable to review this resident. In this research, the GPs were favourable to the role of the NP and indicated that this role can improve access of care for residents in LTACFs. It was also highlighted by some GPs that gerontology is a specialist field and therefore requires specialist knowledge. In reference to the NP role, some participants saw the NP as this specialist. Both cohorts were of the opinion that the NP can lessen the burden of the GPs' workload. Truscott (2007) states that access to care for residents can be improved if GPs and NPs work in collaboration to meet the demands of the older adult population. Further, the care this population is receiving from the GP and RN is generalist care rather than specialist. The need for specialist care is supported by the GP who stated that they undertook further study so that they could provide more specialist care to this population.

The increasing complexity and growing dependency of residents, as well as the changing nature of aged care, have been highlighted in the literature. In this research, it was identified that, on average, hospital-level residents have three to four co-morbidities, which increases the complexity and dependency of these residents. Clark et al. (2014) state that "based on increased life expectancies, older people create a health care resource dependent population" (p. 1592). They further explain that ageing is costly because of the increased complexity and co-morbidities that are associated with ageing.

Carryer et al. (2010) recognised that the workforce providing care to the older adult population is already strained and that the demanding nature of the older adult population will continue to grow due to factors such as hypertension, sedentary lifestyles, and altered diets. Carryer et al. (2010) further noted that “as the public health system becomes overwhelmed by the increasing acuity and chronicity of patients, so too does the need to transfer unwell older adults into the residential care setting” (p. 11). It was also acknowledged by the participants that factors such as the high staff turnover, poor pay, and RNs initially being unaware of the level of work and responsibility required added to the GPs’ workload. Furthermore, the GPs being relied on to continuously support new staff impacted on care provided to the residents. As has been identified by Richardson and Martin (2004) the cost of staff turnover is multifaceted, impacting on the residents and the dynamics of the group. Staff turnover contributes to the rushed feeling to complete cares, as well as to the cost to the industry in replacing staff and training/orientating them. Why then is the participants’ workload important in relation to the perceptions of NPs in aged care? As mentioned by the author previously, the NP role has been used in the past to fill gaps. An RN participant stated that the NP was able to communicate with the GP at a much higher level than the RN was able to. Moral distress has been seen in workers when they have been unable to provide the care to patients that they deem to be the required care, regardless of whether the interventions required are critical or futile (Wilson, Goettemoeller, Bevan & McCord, 2013). In the context of the aged care environment, the difference between what the RNs deem as necessary care and being unable to deliver that care effectively may result in anxiety and eventual burnout. A definition of moral distress, and one that is appropriate for the aged care sector can arise “when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1993, as cited in Burston & Tuckett, 2012, p. 312). In both community and acute sectors, the role of the NP has been identified as being well placed to co-ordinate care that is timely, and this perhaps is the model of care that should be considered in the aged care setting (Allen & Fabri, 2005). Furthermore, as shown in Peri et al’s. (2013) study, the supportive role of the NP attracts and retains GPs. This supportive role may be extended to the RN cohort, therefore providing some stability to the aged care sector.

In Alexander’s (2008) study, the majority of participants in both cohorts were highly favourable to NPs making the initial assessment. As with this research, Alexander (2008) found that RNs identified the overall concept of the NP role as highly favourable and GPs as favourable. In Mackay’s (2003) study, the initial assessment was also seen as favourable by GPs. However, in Mackay’s study, the majority of GPs were uncertain about the overall

concept of the NP role due to accountability and blurred boundary issues. This research and Alexander's study show a shift in GP acceptance of the NP role over the past few years. A reason for this could be due to the GPs working more with NPs and becoming more familiar with what NPs can do. As identified in this research, two GPs stated that, initially, their colleagues were against employing an NP but that their perceptions changed when they were able to see the benefits the NP brought them.

## **5.2. Staffing issues and lack of time**

A theme that emerged from the RN participants was the ongoing issue of being short staffed and the added pressure it placed on the RNs, GPs, and other workers. The RN cohort identified that the average staff-to-resident ratio was one staff member to five or six residents. The number of residents the RN oversaw ranged from 10 to over 50 residents, and in some cases, 80-100. If the RN were unable to find replacement staff, then the number of residents per staff member would increase. The issue of safer staffing has been highlighted by the NZNO in the past.

The detriment that short staffing brings to resident care and safety was highlighted by Wetle et al. (2005), whose research showed that basic needs of the residents were not met, causing the RNs to be task focused rather than patient centred, with important referrals being missed or made too late. Despite all the literature published, staffing levels in LTACFs still remain an issue identified by the participants. One of the services that LTACFs provide, as found in this research, is palliative care. De Bellis' (2010) research showed that short staffing impacted on care, with RNs actually documenting in the residents' notes they were unable to provide appropriate care due to short staffing.

The results from this research showed that the LTACFs do provide palliative care services. The results also show that, from the comments received, only one participant requested further education on palliative care. Given all the issues discussed so far, are LTACFs adequately equipped to meet the needs of dying people? The RN requires advanced skills, knowledge, and understanding to provide complex care. The results of this research show that we have an already overwhelmed workforce who are trying to provide safe, quality, and specialist care to complex and very dependent residents, balanced against legislative requirements and funding/resource constraints. The added stress of effectively caring for palliative care residents is another specialist field in its own right. What keeps coming through the results of this research is the difficulty of the RNs to appropriately meet the needs of their residents in the timeframe and constraints they are given. The RNs and GPs have commented that the amount of time they spend completing paperwork outweighs the amount

of time they spend with the resident, and that they are working more than their 8 hours a day to meet these requirements. It makes sense that LTACFs are a good place for the delivery of palliative care, especially if the resident has lived in the facility. However, the skill, knowledge, requirements, understanding, and availability of the RNs and GPs to be able to meet these needs must be taken into account.

Phillips et al. (2006) researched the delivery of palliative care in LTACFs in Australia and found that the participants of the study (RNs, ENs, and HCAs) were frustrated that the paperwork requirements and their workload "robbed" them of spending that quality time with a resident whom they considered to be like a family member, especially if the resident was "dying alone" (p. 419). This finding relates back to the moral distress discussed earlier, whereby the restrictions placed on workers prevented them from meeting the standard of care they deemed appropriate for the residents. Further to this, the comment made in Phillips et al.'s. (2006) study regarding the staff seeing the residents as family members touches on the unique relationship that is built between the residents and staff, due to the length of time the residents may spend in the facility. When one cares for the same person day in and day out for a long period of time, it is understandable that the carer may get to know that resident well and their likes and dislikes. Likening a resident to a family member portrays a sense of protection of the resident. This is shown in the results of this research because of the comments made by both the GPs and RNs, who made it clear that the NP would need to work with them and listen to them. These comments show a sense of protection that perhaps they perceive the NP may not to know their resident as well as they do. Therefore, there is a conflict between wanting that specialty knowledge and help but not wanting to lose that relationship with the resident. The results of this research show that there is a sense of frustration among the participants in not being able to spend time with the residents and a difficulty with getting a resident reviewed in a timely manner or providing the resident with the care they deem the resident needs. This frustration extends to when the RNs need to send the resident to hospital because they are unable to provide the care this resident needs due to lack of resources or lack of timely interventions, which may emotionally impact on the RN because they may feel that they have let this resident down. Furthermore, they may be exposing this resident to potential adverse effects in the hospital setting. As mentioned by Phillips et al. (2006), this moral distress extends to the possible death of the resident in the hospital setting, whereby they will "receive their end-of-life care away from 'family'" (p. 419). It is here that the conflict of wanting the NP's help but being reluctant to 'let go' is evident. However, the research undertaken by Ploeg et al. (2013) showed that residents and family

members felt the NP did know them, that the NP's care was resident and family focused, and that the NP did establish a caring relationship.

Given the services the LTACFs provide and the complexity of the residents, and accepted minimum number of staff needs to be enforced in order to provide the quality and safe care of residents (Head, 2010). The lack of staffing was noted by a GP participant, who commented on the busy nature of the staff and that tasks were time focused rather than quality focused. In a study undertaken by De Bellis (2010), the busyness of the RNs, the short staffing, and the fact that all care was time based and hurried were themes that impacted on the quality of care residents received, resulting in negligence and unsafe nursing practice. In the United Kingdom, baseline staffing requirements are identified prior to registration of the facility and at re-registration, and staffing levels are discussed with the Regulation and Quality Improvement Authority. Reference is made to continuous reviewing of staffing levels, and points to consider when determining staffing levels are outlined. Lastly, the word "offence" is used in this document if the regulations are breached (The Regulation and Quality Improvement Authority, 2009). The lack of staff potentially leads to an increased risks of falls, medication errors, and aspects of care being missed due to poor assessments. Furthermore, the amount of RNs' time consumed in trying to find replacement staff results in the RNs falling behind in other core duties. A report that reviewed aged residential care services showed that survey participants believed the increasing acuity and dependency of the residents did affect the staffing levels (Fleming & Taylor, 2010).

The other issue identified was the use of unregulated HCAs who did not have the knowledge or understanding to identify or assess issues. The issue was made evident by an RN respondent, who commented on an HCA who reported good urine output for a resident when she observed the resident near the bed, rather than following the correct procedure of measuring the urine. This issue was further maintained by the GPs who stated that they were unsure about the quality of the information they received from the HCAs and that, at times, what the HCAs and Non-RN Managers deemed to be the issue was incorrect, causing stress for the residents and families. Due to the workload of the RNs and funding issues, the RNs have no option but to rely on the services of HCAs. This point was also identified by Carryer et al. (2010), who mentioned the issues of accountability in these instances. In this study, Carryer et al. (2010) highlighted the RNs' concerns about being accountable for the HCAs' practice, yet the RNs were not involved in the process of employing the HCAs. The issues of accountability were identified as causing "significant stress for registered nursing staff" and "accountable for care provided by people they were reluctant to trust" (Carryer et al., 2010, p.

14). The NCNZ (2011b) identifies that the HCA workforce is not regulated and therefore does not have standardised education requirements and that “their role is determined by their employer and outlined in their job description” (p. 4). The author has experienced similar situations where what have been considered appropriate tasks for HCAs to complete according to the principles of direction and delegation outlined by the NCNZ (NCNZ, 2011b), have resulted in missed care. In conjunction with safer staffing levels, Head (2010) stated that the skill mix of staff needs to be appropriate. As shown in the interviews, some of the facilities have put their HCAs on the ACE programme and a study undertaken by Smith, Kerse and Parsons (2005) found that education provided to HCAs can positively influence the standard of care given to residents.

From the data collected and the literature reviewed, it is apparent that the increasing complexity and dependency of residents do not match the skill level of staff or the staff-to-resident ratio in LTACFs. Although the demanding nature of aged care and the challenges staff face with regards to unregulated HCAs, unsafe staffing levels, and the adverse outcomes that these might cause to residents have been identified, it appears very little has been done by government bodies to consider further funding be given to this sector and enforce minimum staffing levels or training of staff, despite requests from professional bodies to do so. Furthermore, the NCNZ (2011b) states that HCAs are “legally accountable for their actions” (p. 5), the fact remains that the onus of responsibility falls on the RNs’ shoulders. Considering the unmanageable workload of the RNs in aged care, it is difficult for them to oversee the practice of all the HCAs, which may result in poor or missed care and place the RN at professional risk. Further deliberation needs to be given to the equity of the RNs’ accepting overall accountability for the HCAs’ practice. The onus of responsibility is supported by Head (2010) who states:

Frequently poorly paid HCAs are asked to carry out tasks without adequate supervision beyond their knowledge and skill; sometimes they do so out of compassion, because there is no one else available. This places the RN who has delegated the responsibility at professional risk, as under the HPCA <sup>15</sup>Act s/he remains accountable for the tasks delegated to others to undertake. (p. 10)

The ongoing issue of lack of staff (both HCAs and RNs) impacts on the RNs’ ability to provide safe, quality care to the residents. The lack of staffing is another factor that can create a sense of powerlessness for the RN as they are forced to work in an environment ruled by budgets, making it difficult for them to adequately meet the needs of the residents.

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<sup>15</sup> Health Practitioners Competency Assurance Act

The issues of being short staffed, not being paid for completing additional work outside of their paid hours, and being required to complete non-clinical tasks are themes that have emerged from this research. Although the RNs who participated in this research did not raise the issues of not being recognised or reimbursed for overtime, the pressures the workload caused resulted in the participants staying longer than their 8 hour shift, either to complete more paperwork or to actually find out how a resident is doing. The fact that the RNs did not mention money whereas the GP participants raised the issue of not being fully remunerated for their services might be a sign of how the RNs actually perceived and valued not only their roles and skills but also themselves. This perception links to the concept of the invisible role of the aged-care nurse. Furthermore, the frustration of the RNs about completing non-clinical tasks has been highlighted in this research: where an RN commented on the unrealistic expectations of the LTACF on the RN to complete their duties as well as to fill the role of an HCA. This feeling of helplessness and moral conflict did influence the RNs' perception of the NP role because a theme that emerged from the data is that the role of the RN in aged care is isolated and invisible. As evidenced by this research, the RNs were looking to the GPs to provide the support they were lacking in their working environments. Furthermore, like the RNs, the GPs were forced to carry out a balancing act between providing quality safe care to the residents within the constraints imposed by the facilities, including funding, skills and knowledge of the RNs, and staffing issues. The RNs might perceive the NP role as a way to improve the undesirable image aged care has among RNs as well as to provide the "voice" to iron out the issues that contribute to the perceived helplessness. The potential of the NP to "increase the visibility and desirability of gerontological nursing as a career choice and provide on-site nursing leadership" was also mentioned by Carryer et al. (2010, p. 16). From the GPs' point of view, besides easing the burden of their workload and providing them with support, the GPs might view the NP role as a support role for the RNs instead of the GPs providing this support. With regards to residents who are identified as complex or unwell, these residents can be overseen by an NP therefore providing further support to RNs and GPs.

### **5.3. Reduced availability of RNs and GPs**

The minimal availability of RNs was a common theme in the data. A GP who no longer provided care to LTACFs but often visited friends residing in the facilities raised concern over the limited time the RN spent with the residents compared to the amount of time the RN spent completing paperwork. The issue of paperwork and the time the RN spent doing paperwork for the purposes of funding and the accreditation process were highlighted in Tuckett et al. (2009) where the time spent doing paperwork was described as "(un)available

time to care" (p. 2606). This GP also mentioned that the care given to residents appeared to be time based rather than quality based. The participant stated that it often lead to inadequate care being provided and missed assessments by the RNs. In research by Wetle et al. (2005), this concern was also raised by family members who stated that information they received from the RNs was insufficient and that the missed care opportunities by the staff resulted in unnecessary suffering and the late referral and transfer of their family members to the appropriate agencies, such as hospice. This study also found that family members were dissatisfied with the service of the GP and commented on how little they saw the GP.

The availability of the RN to residents and family was not explored in this thesis but was identified in the interviews, with the majority of RNs admitting that they worked more than their 8 hour shift. The main reasons given for the overtime were aspects related to unplanned clinical events such as challenging behaviours seen in dementia, or an increasing acuity of a resident, as well as resource issues related to staffing, and the mandated paperwork requirements identified in the Health and Disability Services (Safety) Act 2001. In the interviews, one RN stated that if she did stay longer than her required shift, it would be to spend time with the resident for the purposes of assessing clinical status, which was not always well done during the shift. The RN also stated that she took the phone with her on her tea break, showing that RNs remained working during unpaid hours. Two studies that researched missed care on shifts surveyed RNs, and aged care was shown to have routine care missed for two main reasons: 1) the skill mix of the staff did not meet the need/complexity of the residents and 2) the RN was identified as the only trained person on a duty, with staff consistently recognising the unbalanced ratio of RNs to HCAs, particularly during after hours (Blackman et al., 2014; Harvey et al., 2014). The RN works frequently in isolation in aged care, particularly after hours with a lack of back up and support. Head (2010) raised this issue of isolation and stated "nurses practise in isolation and there is a distressing trend for nurses working in aged care to be over-represented in the cases that are being referred to the Nursing Council for competence reviews" (p. 9). In a staffing levels survey, the NZNO found that although hospital-level care complexes did meet the requirements of having one RN on duty at all times, in large complexes the number of RNs available on duty remained at one (Networkers, 2005). Comments that highlighted reduced RN availability were linked to the question in the survey regarding the Health and Disability Services (Safety) Act 2001, where respondents noted that the Act and its quality mandates became meaningless. Refer to Results chapter. GPs who responded to the survey had similar statements, saying that the

paperwork reduced patient time; therefore, perhaps the focus of the audit needed to reflect quality patient centre care.

In conjunction with the staffing ratios was the funding of care. The survey and interviews provided commentaries in reference to limited funding to support RNs completing basic cares on residents. However, it should also be noted that, in some cases, RNs refused to complete these cares because it was considered the HCAs' job. It was identified by Beer (2013) that RNs refusing to complete cares could be an issue, especially when RNs were considered to be morally distressed and were overloaded or were suffering burnout. Undertaking basic patient care (as in nursing care), is considered a core function of nursing. When organisations were profit driven and place budget before resident care needs, this care became hidden (Willis et al., 2014). The level of skills and knowledge that is actually required when providing what is considered just basic care is often unacknowledged. As stated by Touhy (1997), "assistance with meeting basic needs for care is the skill nursing brings to people. It is our *raison d'etre*, the essence of our profession" (p. 5). It has been found in other studies that care becomes rationalised when it cannot be given at the correct time and that this missed care is passed to the next shift. As a result of this missed care, the next person regardless of their role (e.g. HCA) accepts the responsibility of the care and the RN no longer deems the care to be their responsibility even though, in effect, the accountability remains with the RN (Harvey et al., 2015). De Bellis' (2010) research also identified this issue and noted that the assessment and monitoring of residents by the RNs was lacking, that the RNs were not following the requirements of assessment outlined in the documentation, and that the RNs appeared to rely on the family members and HCAs to determine and report concerns or changes in resident conditions.

Many NZ RNs have chosen not to go into aged care because of the workloads, responsibility, and poor wages (Head, 2010). Another reason for NZ RNs not going into aged care could be due to aged care being seen as undesirable by these RNs, as was identified in the interviews, despite the obvious need for highly knowledgeable and trained RNs to work in this area. Since many of NZ trained RNs choose not to work in aged care, this potentially leaves gaps in the workforce. The issue of newly graduated RNs not wanting to work in aged care was identified in this research and was shown in the study undertaken by Grealish et al. (2010). It was acknowledged by the RN participant in this research that new graduate RNs would only take employment with a facility if there were no other job opportunities available. The literature has shown that aged care is often seen as an undesirable area of employment and low skilled. This poor image might be contributing to the problems of staff attraction and

retention. As this research has shown, caring for the elderly is difficult and a specialist field and therefore we need to be attracting RNs with the right skills, knowledge, and attitude to deliver this specialist care.

This research also found that the majority of RN participants were overseas trained but that they did not identify from which country they undertook their training. Reference to Philipino RNs was made by the participants who were interviewed. While it is acknowledged that the care provided by the IQNs was considered good care, issues identified by both cohorts were mainly in reference to cultural differences, such as the IQNs being reliant on medical interventions rather than nursing interventions and the differences in respect to care of the dying. A number of academic institutions provide courses that allow IQNs to gain their NZ RN registration. However, it should also be noted that there are Aged Care Providers who currently provide these courses as well. Whilst providing this course can be seen as a source of income for the Aged Care Providers, it is also a way for the facilities to employ RNs to fill the gaps. The NCNZ's (2014b) *Annual Report* identified a total of 2,452 NZ European and NZ Maori working in aged care and a total of 2,347 RNs from other ethnicities working in residential/resthome care. However, the report did not clarify, or make clear, if the other ethnicities identified as working in aged care had obtained their RN qualification overseas. Philipino RNs (742) were noted as predominant in the NZ nursing workforce in rest home/residential care, being only second to NZ European RNs (2,224) in number (NCNZ, 2014b, p. 33).

It was identified by Sparacio (2005) that RNs from developing countries were eager to immigrate to other countries because of better pay and career opportunities. Sparacio (2005) made particular reference to the Phillipines and stated "the Phillipines is relatively unique in that it actively encourages the migration of its nurses by training more nurses than can be locally employed, with the specific intent of supplying the international market" (p. 105). Although Sparacio's research was comparing the use of Philipino RNs in the United States of America, much of what was identified as concerns regarding the recruiting Philipino RNs in that country was recognised by the cohorts in this research. Sparacio (2005) stated that there were language differences that posed limitations for the IQNs and created barriers to communication that resulted in patients, other staff members, and the IQNs becoming frustrated. Communication barriers could also adversely affect patient outcomes. Communication differences also concerned non-verbal communication because the American nurses were required to be assertive, whereas the non-verbal communication of the Philipino RNs was seen as "inattentive, subservient, or disrespectful" (Sparacio, 2005, p. 107).

Furthermore, Sparacio highlighted the differences in “cultural and professional values” between the Philippines and American nurses in that the “the American nursing profession values autonomy, for example, whereas Philipino nurses often have a more technical role, following physician instructions, American nurses are encouraged to practice autonomously” (p. 108). In addition, how does providing comfort to someone during the palliative phase fit in with other cultures where nurses will do everything to support living? This cultural difference was commented on by a GP in this research, who stated that at times they had to ask the nurse to stop trying to feed the resident who was clearly in the end stages of life.

The high number of IQNs is important to note because it might influence the perception of the NP role, particularly if the IQN has no previous experience or knowledge of an NP. This lack of knowledge might account for the difference in result between the GPs and RNs when asked if they had previously read about or heard of an NP prior to completing the survey for this research. If there are a high number of IQN working in aged care whose care is based on receiving direction from the GPs, rather than based on autonomy, the idea of a nurse fulfilling what is seen as traditionally medical roles might be unknown to IQNs, altering the favourability of the NP role.

The challenges of inadequate staffing levels and meeting the needs of the residents are not isolated issues that only affect RNs in LTACFs. The data in the research showed the majority of the GPs were of the opinion that there was a shortage of GPs in their area. This finding is consistent with reports from the Royal New Zealand College of General Practitioners (RNZCGP, 2014) and the Medical Council of New Zealand (2012). The RNZCGP (2014) report identified the decreasing number of GPs and the subsequent difficulty of meeting population demands. According to this report, in 1999 per 100,000 New Zealanders, the number of FTE GPs was 84, which decreased to 74 in 2012. This fact is supported by the Medical Council of New Zealand's (2012) report that showed a decrease of 0.6% in the number of GPs from 2011 to 2012. Research undertaken by Alexander (2008) found that the older GP cohort (experience level 10-30 years) believed there was a shortage of GPs in their area, compared with the younger GPs who did not identify that much of a shortage. These findings are consistent with the findings in this research: the GPs with more than 30 years of experience were the majority of those who believed there was a shortage of GPs in their area, and this cohort was identified as being the majority of those GPs working in aged care. In Mackay's (2003) study, 57% of the GP cohort identified as having a shortage of GPs in their area. A perceived shortage of GPs might influence the perceptions of the NP role. The GP participants acknowledged their struggle for them to meet the demands of the older adult

population and therefore they might favour role functions of the NP that made it easier for these needs to be met in a timelier manner, which in turn would reduce their stress and workload.

Further, the GPs stated that it was not always possible for a GP to review immediately a resident considered urgent by the RN. The interviews identified the inability of the practices to absorb the needs of the aged-care sector because all the GPs' time was allocated to seeing practice patients and because the GPs were not always fully remunerated for their time. Examples given by the GP participants were limited funding and being funded a certain amount to oversee residents in facilities. This funding often did not stretch to cover them for doing additional work, such as writing in the resident's notes and their practice notes. This fact was also highlighted by Carryer et al. (2010), who found that the decreasing number of GPs and the limited availability of the GPs' time were two factors that impacted on resident care because interventions were not put in place in a timely manner, resulting in the unnecessary deterioration of the residents and avoidable hospital admissions. Carryer et al. (2010) also noted that admission of the older adult to the ED "is also a source of increased disruption and disorientation for frail older people" (p. 15). These admissions add to the increasing cost and inappropriate use of the secondary and tertiary services. The issue of timely responses by GPs asked to review residents, particularly in acute situations, is not a new issue and has been linked to "delays in treatment, and potentially avoidable presentations to EDs and hospital admissions" (Ouslander et al., 2010, as cited in Peri et al., 2013, p. 10). The demanding nature of providing care to LTACFs and the stress it caused was identified by a GP who had decided to terminate their services to LTACFs and who stated that they would never go back.

The participants in this research referred to the NP role as potentially lowering the number of avoidable/inappropriate admissions to the ED but it is unclear at present how often a nurse referral of a resident to the ED is actually considered avoidable or inappropriate by the ED staff. The research undertaken elsewhere showed that the majority of cases in which an older adult had been were considered appropriate, with a minority being inappropriate. It is acknowledged that what was considered appropriate might be subjective and needs to be defined. Both the studies undertaken in other parts of the world, showed that GPs were only involved in a small percentage of the resident transfer to the ED, which is consistent with the results of this research. The study by Peri et al. (2013) found that the NP role lowered the rates of resident transfer to the ED. As Finn et al. (2006) stated, if staff provided "relatively unsophisticated acute services on site (e.g., administering IV antibiotics)" (p. 432), then the

admission of the residents to hospital could be further reduced. However, who pays for this? What resources do the RNs in LTACFs have to counteract an adverse situation that comes with providing treatments, such as an anaphylaxis, an allergic reaction, fluid overload, and speed shock, since many of the facilities only have access to oxygen in an emergency situation and have very limited access to a GP. Given that those who are over 65 years of age make up 14% of the overall NZ population (Statistics New Zealand, 2014) and given the increase in complexity of health needs, it is reasonable to expect that this age group will be higher users of the acute services. However, as identified by Crilly, Chaboyer and Wallis (2012), resident outcomes are improved if we reduce their admissions to the hospital.

In their report, Fleming and Taylor (2010) highlighted the higher use of external services by the LTACFs and stated that when residents were admitted to the DHB, their acute hospital days were 27% higher than the international benchmark in 2008 for this group of patients. Further, they found that visits to the ED were twice the level of the international benchmark for residents from LTACFs and that the use of prescription medication for this cohort was 42% higher than the international benchmark. In relation to this research, this increased level may be because of the notion that there is no longer an age-defined limit to care, as identified by a GP participant. However, who is deciding this? The difficulty of the advocacy role for the RNs is shown in this research from the found difference in perceived handover quality and the frustration of sending the resident into the hospital because the RN was unable to get the GP in to see the resident or the RN lacked the resources and time as a result of the workload to provide the care to the resident.

In the aged-care environment, advocacy is paramount - what does the resident want? However, this importance seemed to be lost in some cases where the decision was made for the resident because of what was expected and because of unmanageable workloads with the RN and GP participants. This lack of advocacy was noted by Phillips et al. (2006), who said that although the RNs considered advocating for their residents actual needs to be of utmost importance, the RNs acknowledged that they had difficulty achieving this because of the family's wishes or the GP's decision to send the resident to hospital, especially in cases where the GP was too busy to come. In Phillip et al's. (2006) study, it was found that there was despondency on the nurse's part for a variety of reasons when they were required to send a resident to hospital. This reluctance to send a resident to hospital links to the results in this research, where the participants commented that an NP would be able to see their residents faster and to reduce avoidable hospital admissions, therefore keeping the resident in the facility. The difficulty of advocating on behalf of residents links in with the challenges in

communication between the health care professionals. The lack of advocacy is shown in this research, by two factors: by funding constraints and by the RNs who were required to ring their CNM or Manager prior to ringing the GP. This raises the question where is the autonomy was in an autonomous role.

Although it has been shown that the co-ordination of care between LTACFs, GPs, and acute services is a role that the NP could fulfil, thought should also be given to whether an increase in the number of RNs per shift might also improve care for residents in LTACFs. The use of hospital beds by the older adult community was highlighted by Malcolm (2007), who suggested focusing on the primary care settings in order to reduce hospital admissions. With the continued rise in the older adult population and their associated complex needs and dependency, the admission rates of older adults into hospital might continue to rise, as indicated by Bagshaw et al. (2009). As specified by one RN in the interview, hospital-level care in LTACFs was considered "the last port of call" and therefore the LTACF should have been able to provide the level of care the residents needed and wanted. Hospital admissions could distress residents as well as potentially increasing the risk of further medical complications (Foster et al., 2012).

Adding to the decreased availability of GPs is the increasing number of GPs choosing to work part time. This fact was highlighted by a GP in the interviews, who stated that the younger GPs were choosing to work Monday to Friday 08:00 hours to 17:00 hours and were no longer available twenty-four seven. As identified in the Results chapter, this change could explain the lack of response from GPs with 5 years or less of experience in this survey and also the reason GPs were choosing not to provide care to LTACFs. Furthermore, lack of remuneration for services was often identified by the GP participants, and therefore the decreasing numbers of GPs offering services to LTACFs might also be because they see this area as not being a good earner. Another reason for the reduced availability of GP time was given by Clark et al. (2014), who stated that the increasing number of women entering the medical practitioner workforce was resulting in a decrease in the number of hours medical practitioners worked. The RNZCGP (2014) report found that the younger GPs were primarily female whilst the older GPs were mainly male. The report also highlighted that "these younger female GPs are more likely to work part-time and as employees" (RNZCGP, 2014, p. 4). Given the decrease in GP numbers in NZ, the number of patients the GPs reported as seeing in their practice weekly, in combination with the calls for resident reviews from the LTACF, it could be argued that the current workload of the GP is unmanageable and that the ability of the GPs to meet the demands of the population might be difficult and unrealistic.

The inappropriate use of GP time was also highlighted by both cohorts. GP participants stated that they were often more likely to “trust” the information given by an experienced RN. They are required a lower level of support than less experienced RNs. This issue was also expressed by RN participants, who identified that the GP could at times be overwhelmed by the number of residents they were requested to see when attending the facility. An RN participant who acknowledged this issue in the facility was trying to overcome this problem by providing education to the RNs and by encouraging them to find nursing interventions and not to always look for medical interventions. GPs who had set GP visits to the LTACFs each week recognised that these facilities took up less of their time because they were able to build relationships with the staff, be involved in the daily running of the resident care, and better pre-empt potential resident issues.

The NP role has been shown to encourage RNs working in LTACFs to work to the full extent of their scope and to improve their nursing and problem-solving skills, therefore improving resident outcomes and changing the culture of nursing in aged care (Stolee et al., 2006). Although the results of this research show that the majority of RNs understood that the GPs were busy and did not perceive the GPs to have a disinterest in aged care, as identified in the literature, the effects of the GP shortage, the GP workload, and concern over GPs withdrawing their services have rippled through the results in comments such as making better use of the GP time, ringing the CNM or Manager prior to ringing the GP (although this could also be related to cost), and noting a GP had withdrawn their services due to the demanding nature of the aged-care sector. In some facilities, the concern with overburdening the GP with work and meeting the residents’ needs had been managed by having set weekly GP days. The facilities that had one to two House GPs and set GP days seemed more content with the care delivery and the working relationship than those facilities where there were numerous GPs and no set GP days. The better working relationship and allocated time for the GP to spend in the facility might be a reason the staff did not perceive the GP to have a lack of interest in aged care. These two points surely benefit the resident outcomes, as opposed to the GP having no available time to see residents.

#### **5.4. Lack of experience, skill, knowledge base, and professional development opportunities for RNs**

The lack of experience, skills, the knowledge base deficit, and the limited access to professional development opportunities for RNs were consistently identified throughout this research as factors that impacted on quality and safe care of residents. The lack of experience, skills, and knowledge is also a theme that has been identified throughout the

literature. Carryer et al. (2010) identified the lack of knowledge and skills of RNs working in aged care and showed how this lack contributed to the limitations in care provided by the RNs. Other factors were identified as barriers to professional development opportunities: lack of confidence, inability to find staff to cover the RN, lack of own money, and lack of paid study leave. In Tuckett et al's. (2009) study, an RN commented that residents believed that "all nurses are clinically competent" (p. 2609) and the RN acknowledged that there was insufficient education and training in aged care, particularly with reference to palliative care. The identified lack of experience, skill, and knowledge base has been an issue with aged care since Kane et al's. (1989) study. It is important to note that ongoing professional development is a requirement by the NCNZ, falls under the RN competencies, and is required before obtaining an Annual Practising Certificate (APC). This research has shown that, currently, RNs working in aged care are at risk of not meeting this mandated requirement and are therefore placing not only their residents at risk of receiving poor care but themselves in a vulnerable position professionally.

This research looked at the years of experience for RNs and GPs, and not at their ages. It was identified in this research that newly experienced RNs and more experienced GPs in terms of years of experience were in the majority. Although it is acknowledged that years of experience cannot be a direct link to age of the cohorts, it is interesting to note that the NCNZ's (2014) *Annual Report* showed that the majority of RNs working in aged care were between the ages of 25 and 29, followed by the 50-54 age group. Burston and Tuckett (2012) discussed that the more experienced a RN had, the more exposed to moral distress they were. Alternatively, the less experience the RN, was the higher the risk they were to experience moral distress because of their limited exposure to ethically challenging care.

Another theme that emerged in this research that was associated with the lack of clinical skills of the RNs, in that the overall reason for providing hospital-level care was the inability of the RNs to administer subcutaneous fluids and IV therapy. One of the issues raised by an RN participant was that hospital-level care should be able to provide a certain level of care. This issue links to a comment made by a GP who noted the limitations of the RNs not being able to administer IV or subcutaneous therapy. The GP did acknowledge that, in order for RNs to complete certain tasks, they had to demonstrate and be competent in tasks such as IV therapy. However, given the services and level of care that LTACFs are currently providing, it is reasonable to question why RNs working in aged care are not currently required to hold competency in this area, especially when residents are admitted to hospital for the purpose of receiving IV antibiotics. The funding of ongoing competency of these skills for the

facilities, the lack of available time to attend additional study, and the lack of confidence on the part of the RNs were considered barriers to these competencies being obtained. Turrell and Castleden (1999) discussed the possibility of enhancing the treatment given in LTACFs in order to decrease hospital admission rates and to minimise the associated risks of transferring residents to hospital. However, Turrell and Castleden did acknowledge that in order for this to be successful, there would need to be support from primary care services as well as better “preventative, rehabilitative, diagnostic and interventional facilities in nursing homes” (p. 77).

The results of this research have raised concern over the lack of skills/knowledge of the RNs. Furthermore, this research has also found that both groups of participants acknowledged that aged care is specialist care, with one GP commenting on the extra training they needed to complete, in order to feel confident to provide this specialist care. In Phillip et al's. (2006) study, concern from the RNs over the GPs' ability to provide palliative care was raised. The RNs did not acknowledge their knowledge/skill deficits and Phillip et al. (2006) also found that the RNs did not know how to access specialist support. However, this finding could also be linked to the isolated role of the RN. What is apparent throughout this research is that aged care, which is becoming even more specialist, is being carried out by generalists who are having further difficulty accessing external sources to help them provide this care. For those RN participants who previously did have access to external specialist support, imposed funding constraints resulted in these services no longer being made available to them.

#### **5.5. Lack of after hour services**

The results stressed the lack of after hour services, resulting in the RN either trying to make the resident comfortable overnight or sending the resident to the ED, which further increased the cost to the health care system and the risk of potential complications for the resident. With the decreasing number of GPs who are restricting the hours they are available, this issue will continue. During the after hour period, the RN is particularly isolated, increasing their vulnerability and accountability for practice. The lack of after hour services continue to be an ongoing issue that will contribute to the use of secondary/tertiary level services. The literature discussed throughout this chapter supports the benefits of the NP role in aged care including improving resident outcomes and reducing hospital admissions.

#### **5.6. Communication issues**

Communication was identified as an issue throughout the results, such as the quality of handover, the lack of a shared computer system between the LTACFs and the GP practice,

and the lack of communication between the RNs and GPs, and the experts from the DHB. The perceived quality of the handover given by RNs to GPs differed between the cohorts. Only 66.7% of the GP cohort were of the opinion that the handover received from the RN was clear, compared to 98.6% of RNs. The quality of the handover might have been associated with the experience and confidence level of the RN and might have been considered a contributing factor to the time delays for GPs to review residents. One RN participant did acknowledge that the NP gave a higher quality handover than they did. The difference in opinion regarding the quality of the handover could be explained when looking at the participants' comments and when looking at the literature. It has been discussed throughout this chapter that poor communication can impact on care delivery for the resident. Although this research has not provided the answer to why there is a difference in opinion between the RN and GP regarding the handover, it could perhaps be explained by the study undertaken by Phillips et al. (2006). This research showed the frustration and the difficulty RNs face when working with unregulated HCAs, whom they were relying on to provide appropriate care and to report concerns. The GPs themselves expressed concern over the type of handover they get and commented that they were less reluctant to trust the quality of concerns from some RNs. However, Phillips et al. (2006) found that the HCA workforce was a non-technical workforce who struggled to communicate their concerns, which required the RN to change the way they spoke in order to ensure the HCA understood what was required. This change in communication style could result in the nurse losing their skill in using acceptable medical language when communicating with the GP. As identified by Phillips et al. (2006), failure to communicate clearly acted as a barrier to the resident receiving the care they needed. Therefore, given the declining number of GPs and their increasing workload, it is imperative that clear and concise communication is carried out, particularly when the RN requires an already busy GP to review a resident. The lack of a shared computer system has also been shown in this research to impact on resident care. Some GPs expressed frustration over double-handling of documentation that caused the GPs to spend their own time putting the residents' notes into their patient management system. This double-handling increased the risk of an error occurring between the double entries, or resulted in the GP not making additional notes in their practice notes. Again, funding was highlighted as the contributing factor to this issue. The lack of shared electronic communication systems between the facilities and the DHBs, particularly in the case of resident care notes, was an ongoing concern. One RN commented that, at times, neither organisation knew the full care needs of the resident. During the transfer of a resident between the DHB and a facility, limited and, at times, missing information was passed between the two that could have contributed to

increased risk and missed care of the resident. The RN did mention that the implementation of the CNS in the DHB for aged care had improved the communication between the facility and the DHB.

The issue of communication was not just isolated between the RNs and the GPs but extended to the lack of communication among the DHB, RNs, and GPs. Both cohorts expressed a desire to meet regularly with gerontology experts to discuss issues of care and to gain further knowledge, guidance, and support in providing this specialist care. One GP commented on the difficulty of marrying the hours of the specialists with the hours of the GP. This issue could be addressed by implementing an NP role in aged care not only to enhance the collaborative care among RNs, GPs, and the DHB but also to enable the NP to be the source of specialist knowledge. The literature has shown that people with complex needs require a multidimensional approach to their health care from various MDT members. Given that the results of this research show that the majority of residents have on average three or more co-morbidities, their overall care is being undertaken by an RN and a GP. The results of this research also showed that the participants had very limited access to external experts in this field and were eager to have specialist advice/support, including regular ward rounds. Currently, this research only explored the perceptions of participants regarding the NP role. The participants acknowledged that the NP is a specialist and could provide the specialist care that they are enthusiastically seeking. However, the complexity of the residents' needs and the lack of access to specialists might influence the perception of the participants that the NP role could fill the gap in the lack of access to specialist support. Given the comments made by some participants in this research regarding specialist advice and support, it could be determined that the participants are also seeking that specialist support outside the NP role. Furthermore, the difference in opinion regarding a clear resident handover shown in this research could also influence resident outcomes in such a way that if a clear resident handover is not given by the RN to the GP, then the GP may not initially see the need to review the resident immediately.

The majority of the participants were favourable to the NP fulfilling role functions where timely interventions and access of care could be improved for the residents. Interestingly, the majority of RNs were highly favourable, compared with the GPs who were favourable to the NP fulfilling certain roles, namely these functions traditionally considered the GP's role. The reasons the RNs could be more favourable to these role functions compared to the GPs might be because the RNs perceived an increased availability and ability of the NP to implement interventions in a timelier manner, therefore meeting the residents' needs and

ensuring they are accountable and responsible for the care they deliver. It is interesting to note that the RNs were highly favourable to NP role functions that could essentially be seen as RN roles such as undertaking a physical assessment, recommendations of plans to residents/family, obtaining and recording a health history, and deciding when to refer a resident to the GP. This favourability could be because given the identified lack of skills, knowledge, and confidence highlighted by the participants and also because the RNs lack available time to undertake these functions of their role. The RNs might also feel more secure and less vulnerable/accountable with the NP completing these essential tasks. Concerns were raised about the perceived availability of the NP, in that the NP could potentially become just as busy as the GP, which might have also influenced the perceptions of the NP's role functions.

From the GPs' perspective, there were a number of reasons why the GPs were favourable rather than highly favourable to certain role functions, particularly where these role functions were traditionally seen as a GP's role. The GP participants identified a number of issues that impacted on their ability to provide care to residents, such as workload, skills/knowledge of RNs and staffing issues, communication (including handover from the RN), and funding. The GPs acknowledged that it was difficult for them to meet the needs of this complex population and that they perceive there to be a shortage of GPs in their areas. However, given these issues, it appeared that there was an internal conflict for GPs between meeting the needs of this population and using a nurse to do so. Although there has been a shift in thinking with regard to the use of NPs and the willingness of both cohorts to work with NPs since the role was developed in 2000, there was still a misunderstanding and misguided perception of the role of the NP from the GPs' perspective, which might have influenced their choice of favourable instead of highly favourable for certain role functions. It is evident from the results in this research that GPs still considered themselves responsible and accountable for the NP's practice even though the NP would be an independent practitioner who would be accountable for their own practice (NCNZ, n.d.a). This perception could be seen in the comments about wanting to work in collaboration and the reluctance to have the NP working independently. It is apparent that the GPs were wanting to improve access of care to these residents and to have them seen to more quickly with timelier interventions and overall comfort and wellbeing. Although the GPs were favourable overall to the NP role in aged care, funding still remained an issue, as shown in the comments in this research regarding who paid for the NP and the use of a "cheaper" nurse instead of a "more expensive" doctor. This is another interesting point to note because given the scope of the NP, why were they

considered a cheaper alternative to a GP? The concerns around medico-legal issues could be seen in the participants' response regarding legal problems, whereby the majority selected "very few problems", and regarding funding of the NP role, the majority of participants selected "some problems". In Alexander's (2008) study, the GPs were highly favourable to the NPs prescribing with doctor's collaboration and other role functions for which the GPs in this research selected favourable. The changes in the GPs' observed favourableness between Alexander's study and this research might again lie in the differences of perceived accountability of the GP for the NP role as well as the funding issues, accountability, and workload between primary care and aged care (i.e. in their general practice the GP might be able to influence the practice and funding of the NP, whereas this might not be possible in an aged care setting).

To address the issue of funding, the concept that emerged from the participants was the role of the NP could be shared across the DHB, PHO, and Aged Care Provider. The reason for this theme was because when a resident became unwell, this impacted on all three organisations. However, as stated by an RN participant who was concerned with the funding received from the DHB, often in times of funding shortages, cutbacks to the aged-care sector were often the first to be made as was shown in the reduced role function of the CNS.

What became evident after reviewing the data was the participants' ambivalence of the NP role in aged care. In some instances, there appeared to be a level of "patch protection". Although the participants were wanting to use the extended scope and knowledge of the NP, what was clear was nurses should be nurses and should not be general practitioners. Therefore, what might influence this ambivalence is the use of the word "nurse" and what it has always meant in the traditional sense. One of the comments from a GP participant emphasised that if a nurse wanted to be a doctor, then they should have trained as a doctor and another comment emphasised the relief of a GP who was grateful none of his RNs wanted to be an NP. The use of the word "nurse" may have also influenced the comments such as the NP completing the paperwork, managing falls and educating staff, and a comment from an RN who was concerned that the role of the NP might do away with RNs, and that the NP role should be a collaborative role with the GP. However, it should be acknowledged that some GPs identified the need to see these expert nurses being used effectively rather than placing them into roles that were paperwork based. The use of the word "nurse" might be causing the participants to view the NP in the role and scope of an RN and the traditional roles of a nurse rather than as a practitioner in their own right. This idea is supported by the majority of the participants selecting "very few problems" with nurses'

acceptance of the NP but “some problems” with the GPs’ acceptance of the NP and the mention of patch protection from one GP, who acknowledged that other GPs might feel threatened by the NP role. The threats to the GP role were also found in the study undertaken by Wilson et al. (2002), when the role of the NP was being developed in general practice in the United Kingdom. In this study the GPs had concerns about the NP deskilling them, the NP being a nurse and not having the appropriate knowledge to do the job, loss of income and self-esteem, issues related to funding, and the traditional role of the nurse being a handmaiden to the doctor and following the doctor’s orders. However, Wilson et al’s. (2002) study also found that those GPs who already had experience with NPs had their initial concerns resolved after they had worked closely with the NP. The same was been found in this research: the GPs who had experience with NPs were willing to allow the NP to practise autonomously or independently but were still available to discuss issues the NP might have.

Clark et al. (2013) noted the difficulty LTACFs had accessing GPs and also the declining number of GPs who actually visited LTACFs. Their study noted that there was a role for the NP in aged care and that this role could improve resident outcomes. The study undertaken by Peri et al. (2013) to evaluate the NP role in aged care showed that the role positively impacted on the issues identified by the participants in this research. Peri et al. (2013) showed that the NP role increased staff confidence and reduced staff anxiety, decreased admissions to the ED and hospital, enabled residents to be reviewed in a more timely manner, reduced polypharmacy, attracted and retained the GPs because they felt supported by the NP, and enabled the NP to co-ordinate and collaborate care at a higher quality between the facility, GPs, and specialists at the hospital.

## **5.7. Conclusion**

This chapter has identified issues that are impacting on the ability of RNs and GPs to provide quality care to residents. What this research has also found is that the issues identified here support previous studies that have focused on the aged care sector. As previously mentioned, it is important to know the issues the participants considered to impact on their ability to provide quality care to residents because these issues might influence their perceptions of the NP role in aged care. The results of this research showed a workforce that is stressed and unable to meet the needs of this increasingly complex and demanding population. As recognised earlier, if carers know the needs of their residents but are unable to provide sufficient care to meet those needs for whatever reasons, moral stress and passing the responsibility to the next person occur, which further impacts on residents’ care. Therefore, given the issues identified above, the participants might perceive the NP role more

favourably as a model of care that would help meet the needs of this growing population and reduce the stress and workload they currently face. However, given the need to improve access of care to the older adult population residing in LTACFs, the author can see that there is a place for both GPs and NPs in aged care, and other studies identified in this research have shown that a collaborative approach has a very successful outcome for the resident. The next chapter will discuss the conclusion and identify the recommendations outlined from this research.

## CHAPTER 6

### Conclusion, Recommendations, and Limitations of the Research

#### 6.1. Conclusion

This research set out to explore the perceptions of the RNs and GPs regarding NP-led care in LTACFs in NZ. The objectives of this research were to understand the workload demands of RNs and GPs, to determine if the viewpoints of each cohort regarding NP-led care differed and the reasons for this, to determine if the issues raised in previous research were still present, to identify factors that might influence the RNs' and GPs' perceptions, to explore ways by which access of care could be improved for residents, and to make recommendations based on these findings.

This research found that there are many workload challenges currently facing RNs and GPs working in LTACFs that are impacting on their ability to provide quality and safe care to residents. Factors influencing workload, such as complexity and dependency of the residents, the number of residents/patients allocated to RNs and GPs, short staffing, an unskilled workforce, and being forced to work within mandated requirements and restrictive budgets, were all identified as impacting on the provision of safe and quality care to residents. The unmanageable workload was found to affect resident outcomes, and these factors influenced the perception of the NP role in aged care.

Both cohorts were favourable to the NP role in aged care and were of the opinion that the NP could improve access of care and enhance quality of care for residents, budgeting issues. Uncertainty of the NP role, and concern over the NP scope of practice and authority of care remain ongoing issues. Those who had no experience in working with NPs were more comfortable with the NP working in collaboration with the GP. Both groups identified their willingness to work with an NP and identified significant aspects of the NP role that would improve resident care, reduce hospital admissions, prevent unnecessary deterioration of the resident, ease their workload resulting in reduced moral distress, provide a supportive role to both RNs and GPs, provide ongoing professional development and education opportunities for RNs and staff in LTACFs, and above all provide that specialist knowledge this area so desperately needs. However, it should be noted that an increase in the number of RNs and HCAs per shift might also improve access of care for residents in LTACFs. The NP role was also considered to be a factor making the RN role visible and accessible to other health care members as well as a way to raise the profile of aged care.

## **6.2. Limitations of the research**

A limitation of this research was the inability to use all the data gathered in this research because the RNs who answered the survey via hardcopy were not restricted to the same constraints as the RNs who answered the survey via SurveyMonkey™. As this discrepancy resulted in a different scope of answers between SurveyMonkey™ and hardcopy, the additional responses were discarded from the subsequent analysis. The discarded data can be found in Appendix 4.1.4

Another limitation to this research was when the surveys were ready to be distributed, an Aged Care Provider who had initially consented to participate in this research withdrew. The withdrawal of this Aged Care Provider reduced the number of facilities and RNs that could be surveyed. This withdrawal required the author to change the original approach and seek participation from other Aged Care Providers.

The sheer volume of data that was gained from this survey was way beyond expectations, with so many themes detracting from the focus of the NP role, yet intricately woven with it, made it difficult at times to make sense of the data. Because of the limitations of a 60 credit thesis, the themes were not fully explored.

## **6.3. Recommendations**

Further research into the funding of services to LTACFs is needed, and consideration should be given to the funding of the NP role across three sectors, namely the Aged Care Provider, the PHO, and the DHB services, in order to make this role more accessible to the health care sector and to ease the workload of the GP. It is recommended that LTACFs reduce the number of GPs associated with their facilities and rather focus on building relationships with either a House GP or NP, in combination with set weekly clinical days. As concern has been raised around the NP role in relation to autonomy, funding, and in some cases lack of knowledge about what an NP could do, it is recommended that a collaborative approach between the GP and NP might be the start to a shift to a different model of care.

It has also been shown in this research that further education is needed about the NP role because confusion about this remains. It is also recommended that further research occurs around the analysis of the word 'nurse' in Nurse Practitioner, to determine if the use of this word influences how the role is understood and perceived.

The issues of short staffing, lack of skills, and the isolated and invisible role of the RN contribute to resident care and outcomes. Therefore, it is recommended that further research is undertaken on current staffing levels in LTACFs and that mandated legislation is enforced

regarding the skill mix of staff and the minimum number of residents per RN and HCA, based on acuity level and needs of residents. It is recommended further research to adequately determine the number of RNs and HCAs required on each shift in relation to resident complexity be undertaken. The number of skilled HCAs and RNs available per shift should be determined by a recognised accreditation criterion that needs to be met. This criterion being met would also provide more support for RNs and reduce their working in isolation, which might improve resident outcomes.

The literature has shown that people with multiple co-morbidities require an MDT approach to their care, which this research has shown can be lacking. Therefore, it is recommended that further research regarding RNs current access and knowledge of access to external support be undertaken, and ways found to improve access to external specialist support. Furthermore, this research has emphasised that aged care should be recognised as a specialist area of care and therefore this recognition should be extended to the requirements and knowledge base of the RNs. It is recommended that RNs be required to complete advanced education and practice in gerontology and that all Aged Care Providers create a pathway of Professional Development and Recognition Programmes that are recognised by the NCNZ. The requirement of further education should be a mandated requirement, necessitating RNs to advance their knowledge and skills from sources such as recognised academic institutions rather than the generalised education provided by the Aged Care Providers. This education will increase the knowledge base and skill set of the RNs and will improve the quality of care to residents as well as the RNs' confidence. Furthermore, given the services aged care provides, RNs working in aged care need to increase their skill competence in order to provide better access to care for residents, improving resident outcomes, and potentially lowering the professional risk RNs are currently placing themselves in.

Efforts should be made to improve the undesirable image of aged care. To encourage student nurses to consider a career in aged care, further research into how aged care is delivered in the undergraduate nursing programme is needed. Furthermore, further research into the benefits/risks of privatisation of LTACFs compared with Government-owned LTACFs should be considered, including pay disparity of aged-care RNs compared to their peers.

This research has shown that the care of the older adult is complex and demanding. This research has also shown the risk to RNs and GPs when relying on HCAs to report changes in resident conditions. Therefore, further research around the risks of having an

unskilled workforce care for a complex and demanding population should be undertaken. HCAs should be required to undertake recognised education and training such as the ACE programme prior to working in LTACFs, with nationally recognised ongoing training and consideration given to making the HCA role a regulated role.

Intentions of this research were not to discuss cultural differences between NZ trained RNs and IQNs when providing care to residents, and therefore discussion around this subject was not in depth. However, this research has identified differences in role functions between NZ-trained RNs and IQNs. Therefore, it is recommended that further research be undertaken to explore the difference in culture with regard to care expectations and role functions and to determine the impact this difference is having on residents and the IQN.

Further research in NZ is needed around how many residents are actually admitted to the ED each year and how many of these admissions are actually considered inappropriate. Research to understand the resident/family's point of view about care provided in LTACFs in NZ would also be beneficial. Lastly, this research has identified an imbalance between paperwork requirements to meet legislative requirements and direct care time the RN spends with residents. It is, therefore, recommended that further research into this issue is undertaken, with the purpose of finding ways to reduce risk-adverse behaviours so the focus of the RN can be turned back onto the resident.

## Reflection

What an interesting and incredibly frustrating journey of self-discovery this research has been for me. At times, I have felt discouraged with this journey not because I found it boring or irrelevant but because of how close to home this research has been for me. Sometimes the emotional journey research can take you on is unknown until you explore the research yourself. The extent of the issues facing the aged care workforce I did not consider or perhaps fully understand before undertaking this research. I now realise that my time spent practising in an LTACF was a time spent working in isolation with an unawareness of the level of responsibility I was actually accepting as an RN with an incredibly siloed viewpoint. Furthermore, after undertaking this research, I can now say that my vision was very narrow during my practice in an LTACF. I say narrow because I never thought to challenge the “norm” or the Aged Care Provider about their imposed restrictions. Rather, I just accepted that was the way things were. Although I can see the NP role as potentially being one solution to closing the gap in care, it will not change the fact that more skilled RNs and HCAs are actually needed as well. I can recall myself telling HCAs at times that they were lagging in their cares and needed to hurry. After all, the expectation was that all the residents needed to be up before 10am. I guess it is safe to say that I became “institutionalised” to conform to the budgets and paperwork requirements and never considered challenging the fact that this was “robbing” the resident of quality and skilled care or asking why do we need to have all the residents up by 10am. During the writing of this research, the issues identified by both cohorts made me aware of the situation I and my colleagues actually faced working in aged care and this upset me because I began to realise the issues impacting on residents receiving the care they needed was multifactorial and because of the level of risk I was unknowingly accepting at times. Looking back, I was one of those RNs who did see aged care as undesirable and low skilled. I promised myself that I would never work in aged care and that I always saw myself as being a nurse who worked in the acute care setting. However, my actual journey through my career has led me to aged care. It was not until I began to work in aged care that I realised that it was not an unskilled area and I have started to challenge those who deem it to still be the case—at a novice level of course. I hope that those who choose to read this research are able to gain support from it and that this research gives them the opportunity to identify ideas and explore opportunities that will ultimately improve access of care to this special population and to challenge the norms that do not make sense or seem right. Someone once asked me: “why do we nurse?” The answer: “we nurse because there are people who provide a need for our services and it is because of this need, we must always

ask ourselves with whatever we do, where the resident in all of this is". Before finishing I would like to leave you with this quote:

As Callahan (1994, p. 398) has more recently reminded us, we may be victims of our own successes: it is the success of medicine, not its failures, that has created the problem of sustaining and paying for decent health care for the elderly. It is the success of the campaign against ageism, increasing the expectations of everyone for a medically and socially transformed old age, that has added to that problem. If there is any blame to be apportioned it should be directed at our dreams, some of which have come true. It is just that we did not know what that would mean. Now we are finding out. (Pruchno & Smyer, 2007, p. 2)

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## Appendices

## Appendix 1

### Ethics approval

1. First Ethics Committee approval to proceed with the research
2. Letter of request to add two additional questions to the survey
3. Second approval from Ethics Committee in response to additional survey questions



Reference Number 28/14

30 June 2014

Vicki Klein  
Masterate Nursing Student  
C/- School of Nursing  
EIT

Dear Vicki

I am pleased to inform you that your research project “Nurse Practitioner-led Care in Long Term Aged Care Facilities in New Zealand: An exploratory study of Registered Nurses and General Practitioners’ Perspectives” was approved by the Research Ethics & Approvals Committee at their meeting held on 27 June 2014.

The committee have also suggested that you spell check your documents to correct minor typing errors throughout.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wishes you well for the project.

Yours sincerely

**Jeanette Fifield**  
Secretary – Research Ethics & Approvals Committee

cc: Dr. Clare Harvey, Alannah Meyer

04 August 2014

Vicki Klein

To whom it may concern,

**Re: Ethics Approval for Additional Two Questions to be added to Surveys: Nurse Practitioner-led care in long-term aged care facilities in New Zealand: An exploratory study of registered nurses' and general practitioners' perspectives**

I would like to add the following questions to my surveys:

1. In your opinion, what are the reasons LTACFs are audited by the designated auditing agencies?

Comment:

2. In your opinion, in order to meet the requirements outlined in the Health and Disability Services (Safety) Act 2001, do you believe that the mandated audits have assisted in identifying/improving the safety and care provided to residents in LTACFs?

Yes

No

Comment

The aim of my research is to identify models of care that will ultimately improve access of care to residents residing in Long-term aged care facilities. By exploring the RNs and GPs views regarding Nurse Practitioner-led care in these facilities, it will also be of interest to gather their views regarding the current auditing process and if they feel this contributes to improving residents' care. This data can be used in combination with the views of the Nurse Practitioner role and ultimately aid in making recommendations.

Kind regards,

Vicki Klein



Reference Number 28/14

4 August 2014

Vicki Klein  
Masterate Nursing Student  
C/- School of Nursing  
EIT

Dear Vicki

Further to our correspondence, thank you providing further clarification to the Committee, as requested.

Your research project "*Nurse Practitioner-led Care in Long-Term Aged Care Facilities In New Zealand: An Exploratory Study of Registered Nurses' and general Practitioners Perspectives*" was approved by the Research Ethics and Approvals Committee at their meeting held on 25 July 2014.

You are reminded that should the proposal change in any significant way, then you must inform the Committee. Please quote the above reference number on all correspondence to the Committee.

The Committee wishes you well for the project.

Yours sincerely

**Jeanette Fifield**  
Secretary – Research Ethics & Approvals Committee

cc: Dr. Clare Harvey, Alannah Meyer

## Appendix 2

### Covering letters, surveys, and interview questions

4. RN Covering Letter
5. RN Survey
6. GP Covering Letter
7. GP Survey
8. Interview Questions



Faculty of Health Sciences  
*Te Manga Pūtaiao Hauora*

501 Gloucester Street, Taradale, Napier 4112

Dear Participant,

**Nurse Practitioner-led care in long-term aged care facilities in New Zealand: An exploratory study of registered nurses' and general practitioners' perspectives**

I am a Master of Nursing candidate enrolled at the Eastern Institute of Technology (EIT). I propose to research the perspectives of Registered Nurses (RN) and General Practitioners (GP) regarding Nurse Practitioner (NP)-led care in long-term aged care facilities in New Zealand.

The reason for my study is to explore ways to improve access of care for residents residing in these facilities. To do this, I would like to find out what the views of the RNs are in relation to a NP model of care. Also, it will explore the view of the GPs on how they could be supported in that care provision using extended nursing roles. My Supervisors are Associate Professor Clare Harvey and Alannah Meyer from the EIT.

Participants will have the option of completing an anonymous survey online via a programme called Survey Monkey (please type the following link into your web browser: <https://www.surveymonkey.com/s/CLO2ZRW>), or returning the survey via post. A self-addressed return envelope will be provided. Your participation is voluntary. By returning your survey consent to participate in the study will be implied. Unless you have consented to participate in the interview please do not provide your contact details or any identifying data as all surveys need to remain anonymous.

The second part of the data collection will be interviewing participants that have consented to an interview via the initial survey. In accordance with ethics approval for research, although anonymity cannot always be guaranteed, all information will be managed sensitively and no names or places will be used in any report. Also, all raw data will be stored on a password protected computer and/or locked filing cabinet.

Interviews will be recorded using a digital recorder and transcribed by acknowledged transcribers used by EIT. A copy of the transcript can be given on request. All information will be coded and only the researcher and supervisors named in this letter will have access to raw data. Your employment will not be jeopardised in any way by participating in this study.

If you have participated in the interview, you have the right to withdraw from the study during the data collection phase. Prior to answering the attached questionnaire, please read the scope of the NP as outlined by the Nursing Council of New Zealand (2008) provided at the end of this letter.

I have received ethics approval from the EIT Research and Ethics Committee.

It is anticipated that the results of this study will be published as a thesis and may be available to journals and conferences. A copy of your transcripts or the results can be given on request. A copy of the thesis can be found in the Twist Library at the EIT.

Please do not hesitate to contact me if you require any further information regarding my topic or my proposed approach. My contact details are \_\_\_\_\_ You may also contact my Principal Supervisor, Associate Professor Clare Harvey, email [charvey@eit.ac.nz](mailto:charvey@eit.ac.nz) or Tel 06 9748000 ext 5714.

Thank you in advance for taking the time to read this letter and for participating in this research if you choose to.

Kind regards, Vicki Klein

### **NP Scope of Practice**

*“Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people’s health needs. They provide a wide range of assessment and treatment interventions including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse Practitioners may choose to prescribe medicines within their specific area of practice. Nurse Practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities and local and national policy development.”*

(Nursing Council of New Zealand, 2008, p. 2)

## How to proceed with this survey

The reason for this study is to explore ways to improve access of care for residents residing in long-term aged care facilities in New Zealand. To do this I would like to find out what your views are in relation to different models of care that may include Nurse Practitioners.

By now you would have read the covering letter and instructions in regard to the participation in this study.

Please continue with the survey. You do not need to answer questions that you are not sure of. Submission of this survey is consent for the information to be used.

Only complete the information at the end of the survey if you wish to be interviewed.

For further information, please refer to the information sent to you. If you require further clarification please contact me as per information provided in the covering letter provided.

## Demographic data:

The aim of this section is to gather data to gain demographical information of the participants involved in this study. Please tick a response that best indicates your answer.

1. Have you read or heard about Nurse Practitioners (NPs) prior to receiving this questionnaire?

Yes

No

2. Have you discussed with other doctors or nurses the idea of NPs providing health care in long-term aged care facilities (LTACFs)?

Yes

No

3. In your opinion, would the services of a NP enhance the delivery of health care in LTACFs?

Yes

No

Comment

4. How many years have you been practicing as a RN?

0 – 5 years

6 – 10 years

11 – 20 years

21 – 30 years

More than 30 years

5. How many years have you been practicing in a LTACF?

0 – 5 years  6 – 10 years  11 – 20 years  21 – 30 years

More than 30 years

## Workload Assessment:

The aim of this section is to gather data to gain an understanding of your workload.

6. How many hospital level residents are you responsible for during your eight hour shift?

- 10-20
- 21-30
- 31-40
- 41-50
- More than 50

Please state the number of residents if above 50:

7. Over and above the three monthly reviews, please state approximately how many residents you would request a General Practitioner (GP) to review weekly?

- 1-5
- 6-10
- More than 10

Please state the number of residents if above 10 and explain your reasons for that:

8. How many GPs do you work with?

- 1-5
- 6-10
- More than 10

Please state the number of residents if above 10:

9. In your opinion, when you have requested a GP to review a non-urgent resident, when is the GP most likely able to review the resident?

- During their lunch break
- Once they have seen all my practice patients for the day
- The next morning on their way to work
- Immediately

Comment

10. In your opinion, when you have requested a GP to review resident urgently, when is the GP most likely able to review the resident?

- Immediately
- In between seeing their practice patients on the day requested
- They will request the resident is sent to hospital via an ambulance immediately

Comment

11. In your opinion, do you believe you give a clear handover to the GP when requesting the GP to review a resident?

Yes

No

Comment

12. Do you use the Identify, Situation, Background, Assessment and Recommendation (ISABAR) method of handover?

Yes

No

Comment

13. In your opinion, is it always possible for the GP to review residents considered urgent by you immediately?

Yes

No

Comment

14. In your opinion, do you think a NP can improve access of care to residents in LTACFs?

Yes

No

Comment

15. Would you be willing to work in collaboration with a NP?

Yes

No

Comment

16. Please tick one response that indicates how you personally feel about the nurse practitioner performing each of the following role functions:

	Highly favourable	Favourable	Uncertain	Unfavourable	Highly Unfavourable
Makes the initial assessment of an individual's health- illness status when he or she enters the healthcare system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribes medications with doctor collaboration	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
Prescribes medications as directed under the appropriate medications Act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Highly favourable	Favourable	Uncertain	Unfavourable	Highly Unfavourable
Evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provides health teaching to patient and family in order to maintain or promote health, and to prevent illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performs a physical examination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Recommends plan for healthcare to patient and family based upon clinical findings and in consultation with a doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Makes home visits to do follow-up evaluations of the condition of the patient and their family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Initiates treatment and therapeutic regimens of commonly occurring, acute health problems of individuals according to standing orders authorised by a doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obtains and records the patient's and family's health history	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Undertakes the resident's three monthly review	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coordinates healthcare of individuals and family referral to other health professionals and/or community agencies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
With written guidelines, makes decision regarding when to refer patient to a doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Manages routine healthcare of essentially well individuals

Orders routine laboratory studies as indicated

Manages stabilised, long-term and chronic illness of individuals in all age groups

Participates with doctor in continuous evaluation of the quality and effectiveness of healthcare

Provides counselling regarding the health-illness problems of the individuals and families

Contributes towards the education opportunities of others in LTACFs

Overall, how do you feel about the nurse practitioner concept?

17. Please indicate your perception of the following in the utilisation of a NP. Tick the one response which is most representative of your view.

	No Problems at all	Very few problems	Some problems	Many problems
Patients' acceptance of NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctors' acceptance of a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurses acceptance of a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of services rendered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal problems (licensure, malpractice etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interference with doctor-patient relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Availability of funds to cover NP services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demands on doctor time for supervision and/or consultation with a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. In your opinion, what are the reasons LTACFs are audited by the designated auditing agencies?

19. In your opinion, in order to meet the requirements outlined in the Health and Disability Services (Safety) Act 2001, do you believe that the mandated audits have assisted in identifying/improving the safety and care provided to residents in LTACFs?

Yes

No

Comment

**Education:**

The aim of this section is to gather data on current levels of education, education opportunities, and qualifications.

20. Where did you undertake your training?

New Zealand

Overseas

21. Do you hold postgraduate qualifications?

Yes

No

If yes, please state the title of the qualification(s)

22. Are you currently engaged in undertaking postgraduate study?

Yes

No

If yes, what are you studying towards?

23. Do you currently have access to professional development opportunities in your area?

Yes

No

If yes, please state the opportunities you have access to?

24. In your opinion, do these educational opportunities meet your needs?

Yes

No

25. What professional development opportunities would you like to have access to?

26. In your opinion, what factors affect your ability to access these opportunities?

27. Please list any additional comments you may have about the Nurse Practitioner concept and/or this particular questionnaire.

28. Consent to interview

Yes

No

29. Only provide your name and contact phone number if you have consented to the interview

Contact name:

Contact phone number:

Thank you for your participation

## GP Covering Letter & Survey

I am a Master of Nursing candidate enrolled at the Eastern Institute of Technology (EIT). I propose to research the perspectives of Registered Nurses (RN) and General Practitioners (GP) regarding Nurse Practitioner (NP)-led care in long-term aged care facilities in New Zealand.

The reason for my study is to explore ways to improve access of care for residents residing in these facilities. To do this, I would like to find out what the views of the RNs are in relation to a NP model of care. Also, it will explore the view of the GPs on how they could be supported in that care provision using extended nursing roles. My Supervisors are Associate Professor Clare Harvey and Alannah Meyer from the EIT.

Participants are invited to complete an anonymous survey online via Survey Monkey. Your participation is voluntary. By returning your survey consent to participate in the study will be implied. Unless you have consented to participate in the interview please do not provide your contact details or any identifying data as all surveys need to remain anonymous.

The second part of the data collection will be interviewing participants that have consented to an interview via the initial survey. In accordance with ethics approval for research, although anonymity cannot always be guaranteed, all information will be managed sensitively and no names or places will be used in any report. Also, all raw data will be stored on a password protected computer and/or locked filing cabinet.

Interviews will be recorded using a digital recorder and transcribed by acknowledged transcribers used by EIT. A copy of the transcript can be given on request. All information will be coded and only the researcher and supervisors named in this letter will have access to raw data. Your employment will not be jeopardised in any way by participating in this study.

If you have participated in the interview, you have the right to withdraw from the study during the data collection phase. Prior to answering the attached questionnaire, please read the scope of the NP as outlined by the Nursing Council of New Zealand (2008) provided at the end of this letter.

I have received ethics approval from the EIT Research and Ethics Committee.

It is anticipated that the results of this study will be published as a thesis and may be available to journals and conferences. A copy of your transcripts or the results can be given on request. A copy of the thesis can be found in the Twist Library at the EIT.

Please do not hesitate to contact me if you require any further information regarding my topic or my proposed approach. My contact details are \_\_\_\_\_ You may also contact my Principal Supervisor, Associate Professor Clare Harvey, email [charvey@eit.ac.nz](mailto:charvey@eit.ac.nz) or Tel 06 9748000 ext 5714.

Thank you in advance for taking the time to read this letter and for participating in this research if you choose to.

Kind regards, Vicki Klein

## NP Scope of Practice

“Nurse practitioners are expert nurses who work within a specific area of practice incorporating advanced knowledge and skills. They practise both independently and in collaboration with other health care professionals to promote health, prevent disease and to diagnose, assess and manage people’s health needs. They provide a wide range of assessment and treatment interventions including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests and administering therapies for the management of potential or actual health needs. They work in partnership with individuals, families, whanau and communities across a range of settings. Nurse Practitioners may choose to prescribe medicines within their specific area of practice. Nurse Practitioners also demonstrate leadership as consultants, educators, managers and researchers and actively participate in professional activities and local and national policy development.”

(Nursing Council of New Zealand, 2008, p. 2)

### How to proceed with this survey

The reason for this study is to explore ways to improve access of care for residents residing in long-term aged care facilities in New Zealand. To do this I would like to find out what your views are in relation to different models of care that may include Nurse Practitioners.

By now you would have read the covering letter and instructions in regard to the participation in this study.

Please continue with the survey. You do not need to answer questions that you are not sure of. Submission of this survey is consent for the information to be used.

Only complete the information at the end of the survey if you wish to be interviewed.

For further information, please refer to the information sent to you. If you require further clarification please contact me as per information provided in the covering letter provided.

### Demographic data:

The aim of this section is to gather data to gain demographical information of the participants involved in this study. Please tick a response that best indicates your answer.

1. Have you read or heard about Nurse Practitioners (NPs) prior to receiving this questionnaire?

Yes

No

2. Have you discussed with other doctors or nurses the idea of NPs providing health care in long-term aged care facilities (LTACFs)?

Yes

No

3. In your opinion, would the services of a NP enhance the delivery of health care in LTACFs?

Yes

No

Comment

4. How many years have you been practicing as a GP?

0 – 5 years

6 – 10 years

11 – 20 years

21 – 30 years

More than 30 years

5. Do you currently provide care to residents requiring hospital level care in LTACFs?

Yes

No

Comment

6. Do you think there is a shortage of GP services in your area?

Yes

No

Comment

**Workload Assessment:**

The aim of this section is to gather data to gain an understanding of your workload.

7. How many long-term aged care facilities (LTACFs) with a hospital level wing do you provide care to?

1-5

6 - 10

More than 10

Please state the number of LTACFs you provide care to if above 10

8. Over and above the required three monthly visits, please state approximately how many residents you are asked by the Registered Nurse (RN) from the different LTACFs to review weekly?

5-10

11-20

More than 20

Please state the number of residents if above 20:

9. Please state approximately how many patients you will see in your general practice / afterhours weekly.

- 10-30
- 30-60
- 60-90
- More than 90

Please state the number of patients if above 90:

10. For reviews considered non-urgent by the RN at the LTACFs, when are you most likely to review a resident?

- During my lunch break
- Once I have seen all my practice patients for the day
- The next morning on my way to work
- Immediately

Comment:

11. For cases deemed urgent by the RN from the LTACFs, is it always possible for you to review the resident immediately?

- Yes
- No

Comment

12. For cases deemed urgent by the RN at the LTACF, when are you most likely able to review the resident?

- I will review the resident immediately
- I will review the resident in between seeing my practice patients
- I will request the resident is sent to hospital via an ambulance immediately

Comment

13. In your opinion, do you get a clear handover from the RN from the LTACFs when asked to review a resident?

- Yes
- No

Comment

14. In your opinion, do you think a NP can improve access of care to residents in LTACFs?

- Yes
- No

Comment

15. Would you be willing to work in collaboration with a NP?

Yes

No

Comment

16. Please tick one response that indicates how you personally feel about the NP performing each of the following role functions:

	Highly favourable	Favourable	Uncertain	Unfavourable	Highly Unfavourable
Makes the initial assessment of an individual's health- illness status when he or she enters the healthcare system	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribes medications with doctor collaboration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescribes medications as directed under the appropriate medications Act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provides health teaching to patient and family in order to maintain or promote health, and to prevent illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Performs a physical examination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Recommends plan for healthcare to patient and family based upon clinical findings and in consultation with a doctor

Makes home visits to do follow-up evaluations of the condition of the patient and their family

Initiates treatment and therapeutic regimens of commonly occurring, acute health problems of individuals according to standing orders authorised by a doctor

Obtains and records the patient's and family's health history

Undertakes the resident's three monthly review

Coordinates healthcare of individuals and family referral to other health professionals and/or community agencies

With written guidelines, makes decision regarding when to refer patient to a doctor

Manages routine healthcare of essentially well individuals

Orders routine laboratory studies as indicated

Manages stabilised, long-term and chronic illness of individuals in all age groups

Participates with doctor in continuous evaluation of the quality and effectiveness of healthcare

	Highly favourable	Favourable	Uncertain	Unfavourable	Highly Unfavourable
Provides counselling regarding the health- illness problems of the individuals and families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Contributes towards the education opportunities of others in LTACFs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, how do you feel about the nurse practitioner concept?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

17. Please indicate your perception of the following in the utilisation of a NP. Tick the one response which is most representative of your view.

	No Problems at all	Very few problems	Some problems	Many problems
Patients' acceptance of NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctors' acceptance of a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nurses acceptance of a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quality of services rendered	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal problems (licensure, malpractice etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interference with doctor-patient relationship	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Availability of funds to cover NP services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Demands on doctor time for supervision and/or consultation with a NP	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. In your opinion, what are the reasons LTACFs are audited by the designated auditing agencies?

In your opinion, in order to meet the requirements outlined in the Health and Disability Services (Safety) Act 2001, do you believe that the mandated audits have assisted in identifying/improving the safety and care provided to residents in LTACFs?

Yes

No

Comment

Education:

The aim of this section is to gather data on current levels of education, education opportunities, and qualifications.

20. Where did you undertake your training?

New Zealand

Overseas

21. Do you hold postgraduate qualifications?

Yes

No

If yes, please state the title of the qualification(s)

22. Are you currently engaged in undertaking postgraduate study?

Yes

No

If yes, what are you studying towards?

23. Please list any additional comments you may have about the NP concept and/or this particular questionnaire.

24. Consent to interview

Yes

No

25. Only provide your name and contact phone number if you have consented to the interview

Contact Name:

Contact phone number

Thank you for your participation.

### Appendix 3

#### Data distribution table

Table 5

*Number of RN and GP Responses and Skipped Questions to Survey*

Question	RN		GP	
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>
1 Have you read or heard about Nurse Practitioners (NPs) prior to receiving this questionnaire?	72	3	24	0
2 Have you discussed with other doctors or nurses the idea of NPs providing health care in long-term aged care facilities (LTACFs)?	72	3	24	0
3 In your opinion, would the services of a NP enhance the delivery of health care in LTACFs?	69	6	22	2
4 How many years have you been practicing as a RN/GP?	70	5	22	2
5 How many years have you been practicing in a LTACF?	70	5		
Do you currently provide care to residents requiring hospital level care in LTACFs?			23	1
6 How many hospital level residents are you responsible for during your eight hour shift?	74	1		
Do you think there is a shortage of GP services in your area?			23	1

Question	RN		GP	
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>
7				
Over and above the three monthly reviews, please state approximately how many residents you would request a General Practitioner (GP) to review weekly?	71	4		
How many long-term aged care facilities (LTACFs) with a hospital level wing do you provide care to?			17	7
8				
How many GPs do you work with?	73	2		
Over and above the required three monthly visits, please state approximately how many residents you are asked by the Registered Nurse (RN) from the different LTACFs to review weekly?			16	8
9				
In your opinion, when you have requested a GP to review a non-urgent resident, when is the GP most likely able to review the resident?	42	33		
Please state approximately how many patients you will see in your general practice / afterhours weekly.			19	5
10				
In your opinion, when you have requested a GP to review resident urgently, when is the GP most likely able to review the resident?	60	15		
			14	10

Question	RN		GP	
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>
the RN at the LTACFs, when are you most likely to review a resident?				
11 In your opinion, do you believe you give a clear handover to the GP when requesting the GP to review a resident?	74	1		
For cases deemed urgent by the RN from the LTACFs, is it always possible for you to review the resident immediately?			19	5
12 Do you use the Identify, Situation, Background, Assessment and Recommendation (ISABAR) method of handover?	72	3		
For cases deemed urgent by the RN at the LTACF, when are you most likely able to review the resident?			16	8
13 In your opinion, is it always possible for the GP to review residents considered urgent by you immediately?	73	2		
In your opinion, do you get a clear handover from the RN from the LTACFs when asked to review a resident?			18	6
14 In your opinion, do you think a NP can improve access of care to residents in LTACFs?	71	4	18	6
15 Would you be willing to work in collaboration with a NP?	73	2	22	2
16 Please tick one response that				

Question	RN		GP		
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>	
<b>indicates how you personally feel about the nurse practitioner performing each of the following role functions:</b>					
a	Makes the initial assessment of an individual's health–illness status when he or she enters the health care system	74	1	22	2
b	Prescribes medications with doctor collaboration	74	1	22	2
c	Prescribes medications as directed under the appropriate medications Act	74	1	22	2
d	Evaluates progress of patient with prescribed therapeutic regimen and adjusts medications, treatment or therapy in collaboration with doctor	74	1	22	2
e	Provides health teaching to patient and family in order to maintain or promote health, and to prevent illness	74	1	22	2
f	Performs a physical examination	72	3	22	2
g	Recommends plan for health care to patient and family based upon clinical findings and in consultation with a doctor	73	2	22	2
h	Makes home visits to do follow-up evaluations of the condition of the patient and their family	71	4	22	2
i	Initiates treatment and therapeutic regimens of commonly occurring, acute	74	1	22	2

Question	RN		GP		
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>	
health problems of individuals according to standing orders authorised by a doctor					
j	Obtains and records the patient's and family's health history	74	1	22	2
k	Undertakes the resident's three monthly review	74	1	22	2
l	Coordinates health care of individuals and family referral to other health professionals and/or community agencies	74	1	22	2
m	With written guidelines, makes decision regarding when to refer patient to a doctor	72	3	22	2
n	Manages routine health care of essentially well individuals	72	3	22	2
o	Orders routine laboratory studies as indicated	73	2	22	2
p	Manages stabilised, long-term and chronic illness of individuals in all age groups	72	3	22	2
q	Participates with doctor in continuous evaluation of the quality and effectiveness of health care	72	3	22	2
r	Provides counselling regarding the health-illness problems of the individuals and families	73	2	22	2
s	Contributes towards the education opportunities of others in LTACFs	72	3	22	2

	Question	RN		GP	
		Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>
t	Overall, how do you feel about the nurse practitioner concept?	73	2	22	2
17	<b>Please indicate your perception of the following in the utilisation of a NP. Tick the one response which is most representative of your view.</b>				
a	Patients' acceptance of NP	70	5	21	3
b	Doctors' acceptance of a NP	69	6	21	3
c	Nurses acceptance of a NP	72	3	21	3
d	Quality of services rendered	71	4	21	3
e	Legal problems (licensure, malpractice etc)	69	6	21	3
f	Interference with doctor-patient relationship	71	4	21	3
g	Availability of funds to cover NP services	68	7	21	3
h	Demands on doctor time for supervision and/or consultation with a NP	70	5	22	2
18	In your opinion, what are the reasons LTACFs are audited by the designated auditing agencies?	59	16	19	5
19	In your opinion, in order to meet the requirements outlined in the Health and Disability Services (Safety) Act 2001, do you believe that the mandated audits have assisted in identifying/improving the safety and care provided to residents in	69	6	20	4

Question	RN		GP		
	Response (n)	Skipped Question (n) <sup>a</sup>	Response (n)	Skipped Question (n) <sup>a</sup>	
LTACFs?					
20	Where did you undertake your training?	73	2	22	2
21	Do you hold postgraduate qualifications?	70	5	22	2
22	Are you currently engaged in undertaking postgraduate study?	75	0	22	2
23	Do you currently have access to professional development opportunities in your area?	73	2		
	Please list any additional comments you may have about the NP concept and/or this particular questionnaire.			12	12
24	In your opinion, do these educational opportunities meet your needs?	70	5		
25	What professional development opportunities would you like to have access to?	41	34		
26	In your opinion, what factors affect your ability to access these opportunities?	46	29		
27	Please list any additional comments you may have about the Nurse Practitioner concept and/or this particular questionnaire.	13	62		

*Note.* n = number of responses in each category.

<sup>a</sup>The count of skipped number of responses includes discarded data. Discarded data included in Appendix 4.

## Appendix 4

### Discarded data

Table 6

*Number of RN responses that have been discarded*

	Question	Discarded Response (n)
3	In your opinion, would the services of a NP enhance the delivery of health care in LTACFs?	1
4	How many years have you been practicing as a RN?	1
5	How many years have you been practicing in a LTACF?	1
6	How many hospital level residents are you responsible for during your eighth hour shift?	2 <sup>16</sup>
7	Over and above the three monthly reviews, please state approximately how many residents you would request a General Practitioner (GP) to review weekly?	3
8	How many GPs do you work with? Please state the number of residents if above 10	1 5 <sup>**</sup>
9	In your opinion, when you have requested a GP to review a non-urgent resident, when is the GP most likely able to review the resident?	10
10	In your opinion, when you have requested a GP to review resident urgently, when is the GP most likely able to review the resident?	8
14	In your opinion, do you think a NP can improve access	1 <sup>*</sup>

<sup>16</sup> \* indicates that only the comments added to these questions by the participants were discarded, not the responses to the question.

<sup>\*\*</sup>Any response made to the comment box under question 8 was discarded as the comment box question was referring to number of residents instead of number of GPs as intended. It was therefore unclear if the number stated from the participants referred to GPs or residents.

<sup>\*\*\*</sup> Unable to decipher writing.

Question	Discarded Response (n)
of care to residents in LTACFs?	
16 Please tick one response that indicates how you personally feel about the nurse practitioner performing each of the following role functions:	6*
17 Please indicate your perception of the following in the utilisation of a NP. Tick the one response which is most representative of your view.	3
19 In your opinion, in order to meet the requirements outlined in the Health and Disability Services (Safety) Act 2001, do you believe that the mandated audits have assisted in identifying/improving eh safety and care provided to residents in LTACFs?	1
20 Where did you undertake your training?	2
21 Do you hold postgraduate qualifications	1***
24 In your opinion, do these educational opportunities meet your needs?	
24 In your opinion, do these educational opportunities meet your needs?	3*