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General practice nurses' communication strategies for lifestyle risk reduction: A content analysis

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Publication Details Citation

James, S., McInnes, S., Halcomb, E. J., & Desborough, J. L. (2020). General practice nurses' communication strategies for lifestyle risk reduction: A content analysis. Faculty of Science, Medicine and Health - Papers: Part B. Retrieved from <https://ro.uow.edu.au/smhpapers1/1661>

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General practice nurses' communication strategies for lifestyle risk reduction: A content analysis

Abstract

© 2020 John Wiley & Sons Ltd Aims: To explore how general practice nurses (GPNs) communicate lifestyle risk reduction with patients presenting for chronic disease consultations. Design: Qualitative content analysis of video observations. Methods: The audio of 14 video-recorded GPN chronic disease management (CDM) consultations were transcribed verbatim. Deductive content analysis was undertaken using the exploring, guiding, and choosing model, an adaptation of steps used in motivational interviewing (MI). Data collection occurred between August 2017 - March 2018. Results: General practice nurses demonstrated relational skills including the use of open-ended questions, content reflections, and affirmations. However, greater use of collaborative agenda setting, double-sided reflections, summarizing patient priorities, and 'importance and confidence scales' could enhance discussions about lifestyle risk reduction. Conclusion: Although GPNs were using some MI techniques, there was room for skill development. Enhancing GPNs' MI skills has the potential to optimize their effectiveness in communicating about lifestyle risk reduction and the reduction of chronic disease. Ongoing professional development in MI skills and lifestyle risk communication needs to be supported by nurses, workplaces, and educational providers. Impact: This study has identified GPNs' strengths and challenges in relation to lifestyle risk communication. Fostering these skills has the potential to reduce risk of lifestyle attributable chronic disease.

Publication Details

James, S., McInnes, S., Halcomb, E. & Desborough, J. (2020). General practice nurses' communication strategies for lifestyle risk reduction: A content analysis. *Journal of Advanced Nursing*, Online First

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ABSTRACT

Aims: To explore how general practice nurses communicate lifestyle risk reduction with patients presenting for chronic disease consultations.

Design: Qualitative content analysis of video observations.

Methods: The audio of 14 video-recorded general practice nurse chronic disease management consultations, were transcribed verbatim. Deductive content analysis was undertaken using the *exploring, guiding and choosing model*, an adaptation of steps used in motivational interviewing. Data collection occurred from August 2017 - March 2018.

Results: General practice nurses demonstrated relational skills including the use of open-ended questions, content reflections and affirmations. However, greater use of collaborative agenda setting, double-sided reflections, summarising patient priorities and ‘importance and confidence scales’ could enhance discussions about lifestyle risk reduction.

Conclusion: Although nurses were using some motivational interviewing techniques, there was room for skill development. Enhancing general practice nurses’ motivational interviewing skills has the potential to optimise their effectiveness in communicating about lifestyle risk reduction and the reduction of chronic disease. Ongoing professional development in motivational interviewing skills and lifestyle risk communication needs to be supported by nurses, workplaces and educational providers.

Impact: This study has identified general practice nurses’ strengths and challenges in relation to lifestyle risk communication. Fostering these skills has the potential to reduce risk of lifestyle attributable chronic disease.

Key words: counselling, deductive content analysis, general practice, interactions, lifestyle, motivational interviewing, nursing, patient relations, primary care, qualitative.

1. INTRODUCTION

An ageing population and increases in morbidity and mortality secondary to chronic disease present challenges for health care systems internationally (World Health Organization, 2018a, 2018b). To prevent chronic conditions including type 2 diabetes, hypertension, obesity and some cancers, general practice nurses (GPNs) have a key role in communicating lifestyle risk reduction (James, Halcomb, Desborough, & McInnes, 2019). Internationally, whilst there is variability in how roles are enacted, GPNs in countries such as Australia, New Zealand and the United Kingdom have benefitted from funding and policy initiatives supporting increased patient demand for services in primary care (Ministry of Health, 2018; Primary Care Workforce Commission, 2015; Swerissen, Duckett, & Wright, 2016).

Operating in primary care, the GPNs' role includes health promotion, illness prevention and chronic disease management (CDM) (Australian Primary Health Care Nurses Association, 2017). An important part of CDM and health promotion is supporting patient self-management through smoking, nutritional, alcohol and physical activity interventions (Eley et al., 2013; The Royal Australian College of General Practitioners, 2015). Whilst the GPN role in CDM is acceptable and feasible to patients and general practitioners, primary care has been criticized for efforts in redressing the effects of chronic disease, including the under optimization of the GPN role (Desborough et al., 2016; Hegney, Patterson, Eley, Mahomed, & Young, 2013; Swerissen et al., 2016).

1.1 Background

Tailoring communication based on patient need facilitates interactions and supports patient priorities to address behaviour change (James, Halcomb, et al., 2019). This is particularly important for patients with chronic conditions who may have decreased capacity to make changes in lifestyle behaviours due to underlying social determinants of health, illness and

physical capacity (Jolanki & Tynkkynen, 2018). Additionally, person-centred approaches to lifestyle risk communication, such as motivational interviewing (MI), can be problematic in consultations where there are time constraints, unsupportive work environments, a lack of privacy and poor collaborative decision-making between providers and patients (Jolanki & Tynkkynen, 2018).

Motivational interviewing is a person-centred behaviour change approach known to be effective in primary care (Noordman, van der Weijden, & van Dulmen, 2012). Techniques practiced in MI, such as reflections, affirmations, open questions and summarisations are viewed positively by patients as they address ambivalence and help prepare them for feedback and the goal setting necessary for behaviour change (Polcin et al., 2015). Through understanding patient motivation and readiness to make behavioural change, there is linkage to the “Stages of change” model, including the steps of pre-contemplation, contemplation, preparation, action and maintenance (DiClemente & Marden Velasquez, 2002). Examples of MI interventions in primary care include lifestyle risk reduction targeted at cardiovascular risk factors and depression treatment adherence (Hardcastle, Taylor, Bailey, Harley, & Hagger, 2013; Keeley et al., 2014).

Despite these MI interventions, there is variability in how communication about behaviour change is enacted in primary care (Noordman et al., 2012). Research examining GPNs’ use of MI has focused on their experiences, self-perceived use, training or quantitative analysis of the technique (Huntink, Koetsenruijter, Wensing, & Lieshout, 2019; Östlund, Kristofferzon, Häggström, & Wadensten, 2016; Östlund, Wadensten, Häggström, & Kristofferzon, 2014; Östlund, Wadensten, Kristofferzon, & Häggström, 2015). This study aimed to address a gap in the research through qualitative examination of how GPNs support lifestyle risk reduction with patients during chronic disease consultations using MI techniques.

1.2 The exploring, guiding and choosing model

The *exploring, guiding and choosing model* focuses on skills and techniques needed during MI (Resnicow & McMaster, 2012). *Exploring* includes the assessment of lifestyle and behaviour change history, building rapport and collective decision-making about lifestyle risk reduction priorities (Resnicow & McMaster, 2012). Through actively listening and responding respectfully, rapport is developed and priorities understood (Rollnick, Miller, & Butler, 2008). These techniques demonstrate GPNs' interest and encourage patients' involvement in identifying risky behaviours and risk reduction strategies (Resnicow & McMaster, 2012; Rollnick et al., 2008). Exploring techniques include the use of open-ended questions, listening, reflections, exploring ambivalence and agenda setting (Resnicow & McMaster, 2012; Rollnick et al., 2008).

Guiding involves GPNs encouraging patients when they express uncertainty about lifestyle change (Resnicow & McMaster, 2012). This is informed by strategies such as summarising reasons for behaviour change, rating patients' perceptions of the importance of risk reduction and their confidence in achieving this, as well as asking open-ended questions to prompt patients to verbalise change talk (Resnicow & McMaster, 2012). Empowering patients to make decisions related to lifestyle risk reduction can be supported by prioritising importance, building confidence, or using the 'elicit-provide-elicit' approach, where GPNs use patients' knowledge needs, convey information neutrally and understand patient interpretations (Mason & Butler, 2010). Once patients have verbalized behaviour change talk an approach for lifestyle risk reduction can be chosen (Resnicow & McMaster, 2012; Rollnick et al., 2008).

Choosing includes goal setting, action planning, barrier resolution and follow-up (Resnicow & McMaster, 2012). Reflecting on information provided and presenting options decreases the likelihood of a negative reaction to risk reduction (Resnicow & McMaster, 2012).

Collaboratively establishing strategies to achieve risk reduction requires GPNs to work with

patients to reduce tensions related to changing behaviour (Mason & Butler, 2010; Rollnick et al., 2008). Arranging ongoing support and evaluation forms part of the goal setting process (Lenzen, Daniëls, Van Bokhoven, Van Der Weijden, & Beurskens, 2015).

2. THE STUDY

2.1 Aim

This paper seeks to explore how GPNs communicate lifestyle risk reduction with patients presenting for chronic disease consultations. Specifically, we sought to explore the question:

1. What communication skills and techniques do GPNs use to communicate lifestyle risk reduction with patients presenting for chronic disease consultations?
2. How are these skills and techniques employed by GPNs to communicate lifestyle risk reduction with patients presenting for chronic disease consultations?

2.2 Design

This paper is drawn from a concurrent mixed methods project, which sought to explore Australian GPNs' perceptions of and approaches used for, lifestyle risk communication. The quantitative component analysed GPNs' and patients' nonverbal behaviours during video recorded consultations (James, Desborough, McInnes, & Halcomb, 2020). The focus of this paper is a qualitative analysis of verbatim transcriptions of a subset of these video-recorded consultations. Semi-structured interviews with GPNs were also conducted following these consultations and their findings are reported elsewhere (James, McInnes, Halcomb, & Desborough, 2020).

2.3 Participants

A convenience sample of 15 GPNs and 40 patients were recruited, between August 2017 and March 2018, from Primary Health Networks (PHNs) in the south east of New South Wales and Australian Capital Territory, Australia. PHNs are government funded organisations that

support general practices by improving community based services and coordination of care for patients (Department of Health, 2018). Recruitment of GPNs occurred through social media and direct contact with general practices and professional organisations. Registered (baccalaureate prepared or equivalent) nurses (RNs) were targeted as they represent the largest nursing group in general practice (Australian Primary Health Care Nurses Association, 2018). Given the focus of the study, RNs who were employed in a general practice and undertook chronic disease management (CDM) consultations were eligible to participate.

Participating patients were recruited by GPNs if they were adult, English speaking and presenting for a GPN CDM consultation. To reduce selection bias, 2-4 consecutive eligible patients were recruited by each GPN. Consultations where chronic disease care planning, health or nurse-led assessments were targeted because of the probability of lifestyle risk reduction being discussed.

2.4 Data collection

Collection of GPN consent and demographic data was undertaken by the primary researcher. Non-participatory video observation was used to capture GPN and patient consultations due to its acceptability, usefulness in understanding communication techniques in the clinical setting, static physical positioning of lifestyle risk conversations and to reduce the potential bias of having an observer physically present (James, Desborough, McInnes, & Halcomb, 2019). Each GPN was orientated to video recorder operation as they were responsible for video recording. GPNs collected patient consent, medical and demographic data prior to the consultation. Video recordings of consultations took place using two Go Pro Session 4 cameras with micro SD cards (James, Desborough, et al., 2019).

2.5 Data analysis

Due to the large data volume, one representative video was selected from each GPN participant for verbatim transcription by a professional transcription service. Transcripts were initially manually coded by the first author (SJ) using deductive content analysis (Elo & Kyngäs, 2008). Categorization was informed by the *exploring, guiding and choosing model* (Resnicow & McMaster, 2012). Coding data into categories using a model, or structured approach, assists in understanding concepts in different contexts (Elo & Kyngäs, 2008). Data immersion was achieved by two members of the research team (SJ & EH), who reviewed audio files, transcripts, coding and made notes (Elo & Kyngäs, 2008). Transcripts were reviewed several times by the team prior to coding and discrepancies discussed. All team members contributed to the selection of quotations to represent codes. Each member of the research team has experience in nursing and qualitative research in primary care. Data saturation was thought to have occurred at 12 GPN-Patient consultations and confirmed with analysis of a further two consultations.

2.5.1 Ethical considerations

Approval for the study was granted by the University of Wollongong Human Research Ethics Committee (Approval No. 2016/381). Given the nature of video consultations, the storage, transmission and disposal of data was guided by relevant data management policies (Australian National Data Service, 2017; National Health and Medical Research Council, Australian Research Council, & Universities Australia, 2007 (Updated 2018)). Informed consent was gained from nurses and patients prior to the commencement of recording. Patients were advised that their choice whether or not to participate would not have an impact on their relationship with the health providers or researchers. As the nurse controlled the video recording it could be paused or stopped if examinations occurred, however, it is not standard practice for full physical examinations to occur in these consultations. Limiting

access to videos to the research team, meant privacy and confidentiality was assured.

Pseudonyms were assigned to participants to maintain confidentiality.

2.5.3 Rigour

Lincoln and Guba (1985) approach of credibility, transferability, dependability, confirmability and authenticity was used to establish rigour. Credibility was achieved in the validation of content through researchers' experience as a GPN, use of the *exploring, guiding and choosing model* to underpin the analysis, field notes and video recorded data (Resnicow & McMaster, 2012). Transferability was achieved by giving clear description of methods and participant characteristics. Dependability was achieved through transcript review, ongoing research team discussion and careful documentation of field notes and the technique used (James, Desborough, et al., 2019). Confirmability was achieved by linking findings from this analysis to other findings from the project and the broader literature. Lastly, authenticity was shown through the verbatim transcription, video recordings, inclusion of participants' quotations and engagement with the GPNs during the project. Reflexivity was ongoing and involved the research team reflecting on personal biases and their impact on analysis.

3. FINDINGS

3.1 Participants' and consultation characteristics

The 14 consultations in this analysis represented over 7 hours of video recorded data.

Duration of consultations ranged from 18.1-69.3 minutes (mean 31.4 minutes). Participating patients were mostly female (N=8; 57.2%) and had a mean age of 67.3 years (range 48-82 years; SD 10.9). Participant GPNs were all female, with a mean age of 43.5 years (range 25-66; SD 11.8) (Table 1).

3.2 Exploring

As part of new or ongoing care, rapport was established informally through reflections, general open or closed questions. This served to invite the patient to lead discussion about general or medical concerns, the consultation or interests:

Diana: You been behaving yourself?

Patient: Yeah.

Diana: (laughs)

Patient: Still waiting for the surgeon to ring back to see when I'm going in.

Diana: Are you? Yeah. What are we having done?

Patient: A skin cancer.

At the beginning of the consultation, the reason for attending was often clarified by the GPN. The agenda for lifestyle risk discussions was either led by the GPNs' assessment of patient needs or general practitioner (GP) referral:

Bonnie: So, for this one, really what we're going to do is blood pressure, height, weight, your sugar levels and we'll have a bit of a chat about the family history, how you're going with the sleep, diet, exercise, those sort of things.

Patient: Okay.

Behavioural assessment identified some specific lifestyle risk factors, although some GPN assessments were more general:

Janet: You've never smoked.

Patient: No.

Janet: Your diet is well balanced now.

Patient: Yeah. I've taken a lot of the breakfast cereals out.

Other CDM consultations sought to understand behaviours in a more detailed way including alignment with diet, alcohol, or exercise guidelines:

Chrissie: What would you eat for breakfast normally?

Patient: Cereal.

Chrissie: What type of cereal is that?

Patient: Muesli and a piece of fruit usually.

Chrissie: Morning tea?

Patient: Either nothing or some nuts, almonds.

When exploring lifestyle risk with patients, statements of affirmation and encouragement were used by GPN participants to facilitate discussion and congratulate positive lifestyle choices:

Kate:So, I'm actually really happy when I'm hearing you saying your bread - what sort of bread?

Patient: Wholegrain.

Kate: Perfect.

Patient: Nine-grain and I have - I usually have - I like Weet-Bix.

Kate: Excellent.

Demonstrating their listening and information gathering, GPN participants used reflection to clarify understanding and goals:

Patient: Well that was yeah, that was something I was talking to the doctor about as well, just with this - changes going on everywhere so I think it's a bit associated with that. It's not a lot easier - it's harder to lose weight and easier to gain weight.

Bonnie: Yeah, certainly and particularly if you had an injury anyway, you're not being able to do the usual things anyway.

Some conversations demonstrated missed opportunities for further exploration, agenda setting or education related to lifestyle risk. For example; rather than clarify what she meant by margarines and explore the topic in greater depth, Diana moves on with the consultation:

Diana: And, you're watching the margarines you have ...

Patient: What margarines?

Diana: and how much oil you have?

Patient: Yes

Diana: You have been educated on all that. Okay.

3.3 Guiding

No GPN participant explored uncertainty using an importance or confidence numerical scale. Similarly, limited summation of lifestyle risk discussion was observed. However, some guided patients through personalised education, educating them about lifestyle risk recommendations to support potential reasons for behaviour change:

Bonnie: Much alcohol? Do you drink much alcohol?

Patient: Yeah, once or twice a week I'll have something to drink. Probably I might share a bottle of wine or something like that on a Friday night or Saturday night. A couple of beers with it, sometimes.

Bonnie: So keeping to the - the recommendation is one or two. When you get to sort of four, five, six or more, then that's a bit much.

To assist prioritisation of areas where lifestyle risk reduction may have been needed, GPNs attempted to lead patients by revisiting topics, including past successes in the same consultation:

Patient: I don't think I've lost any weight.

.....

Patient:Just not motivated.

Tina: Like motivated like you were.

.....

Patient: Well, I should be motivated, I'm planning on going to Western Australia next year, so I should be getting motivated.

Tina: Then you think - once you've got something to work towards, that will - yeah.

Patient: I hope so.

.....

Tina: What would your aims be for before you head over there?

Patient: I haven't really thought about that, just putting a date down, that's the first thing.

Tina: Before you went to Europe you had that - you were really motivated to - you know, because you wanted to be able to walk around and that was - what would be your thing that you want to...

.....

Tina: No lectures, it's just, you know, channel that - whatever it is that's going to - it sounds like it's going to be locking in a date will help you.

Patient: It will be fairly important.

3.4 Choosing

Some GPNs encouraged patients to engage in goal setting, through content reflections, suggesting options and barrier resolution for lifestyle risk reduction. These discussions were often lengthy and involved action planning, where patients discussed steps toward achieving the desired goal. In this example, the GPN and patient discuss the barriers of lung capacity, glasses and uneven paths before a plan for physical activity is resolved:

Kate: How else - what else are you thinking you might be able to do? Because most people have some sort of a plan. If you're concerned about moving and that's wearing you out, what else are you thinking you might be able to do?

Patient: There isn't anything that I can come up with. I can walk, but I have trouble. These are [multifocals] and I can't see when I walk. The lady at the optometrist said yes, these can affect your sight. I don't enjoy it, worrying where I'm walking.

.....

Kate: Sometimes it's really hard to...

Patient: Get going. [Partner's name] walks, I don't. I'll puff if I go from the back door down to our little garden area where we grow veggies and stuff. I shouldn't, but I do. I'm sure it's just more the weight.

.....

Kate: When you say that, that concerns me. So, let's make sure that you've got good lung function. This is something you'll go over with the doctor. Sometimes, adding in a puffer can assist. ...

.....

Kate: That's really interesting, that you know you'd like to move some more, you're getting a bit breathless, so you're checking out doing some basic stuff to make sure if we can assist with your lung function. But when you try to walk, your glasses are actually what makes it difficult.

.....

Patient: I could most probably go without the glasses to walk. It's something that I just haven't...

.....

Kate: Why don't you try that?

Patient: I will. I'll speak to [Partner's name] because he's more than happy to have a bit of walk around.

.....

Patient: To start with, I think rather than go for the walks because the roads are all uneven...

Kate: Yeah, they're shocking.

Patient: we have concrete verandas the whole way round the house. Now, I thought maybe if I just do that a few times and see how that goes, because it is level and it's easy to walk.

Kate: One of the things to think about it is rather than thinking I've gone around 10 times, just look at a time.

Patient: Do it for five minutes or two minutes, or 10.

Options for lifestyle change were sometimes presented through closed questions and statements that prompted a simple answer rather than encouraging a more detailed response:

Bonnie: Are you taking the skin off the chicken, cutting extra fat off?

Patient: Yeah, yeah.

However, when GPNs used open-ended questions, commitment talk often followed:

Susan: So in order for us to stay on track, what do you think we need to do?

Patient: Well, I've got to get back into the diet; that's virtually it. I've just got to get back to the proper eating again and not so much takeaway's which I do love

Sometimes reflection and affirming statements were used to encourage patient discussion and show empathy for barriers to risk reduction:

Patient: Yeah, I seem to still - I mean after - they [exercise physiologist] got me walking doing three lots of walking each time and it started off with maybe three minutes and I think it got to about a five-minute walk.

Because I was counting it - three was all right, I could handle that, but as they progressed me up the scale, I was finding it more and more difficult.

Susan: More and more difficult, yes.

Patient: When I was - even when I was only doing the five-minute one, I felt by the time I got to 3 minutes, I was counting the laps so then I know I've only got to go...

Susan: Counting it down.

Some GPNs referred patients to allied health professionals as a means to address risk behaviours. Discussions related to this included education about allied health roles and the referral process:

Joan: So it's going to be important though ... to see a dietician, it's going to be really important. That's the whole and complete kind of picture and stuff and really the best program is through community health, because you meet the diabetes educator. Do you have a follow up appointment with [diabetes educator's name]? I don't think so do you?

Patient: No.

Joan: No, there'll be a diabetes educator, there'll be a dietician, there'll be an exercise physiologist and they do group classes once a week for about six weeks. So will that be manageable for you with work?

Patient: Yeah.

Follow-up with patients often occurred as a result of referral from the GP or revisiting goals from a previous consultation with the GPN:

Pat:So you had the care plan done in March and the main concerns that you talked to [GPN's name] about at that time was your breathlessness, which is limiting your activity and things that you're able to do for yourself and it was affecting your sleep as well at that time and some increasing anxiety which probably associated with being short of breath. Does that sound about right?

Patient: [nods]

.....

Pat: [GPN's name] talked about physical activity and you were doing some walking down around the memorial gardens?

Patient: Yep. I still do that.

At the same time as providing guidance and support, GPNs acknowledged and accepted patients' decisions and choices related to managing their lifestyle risk behaviours:

Kate: Absolutely. Do you know, I'd really love to contact (exercise physiologist's name). I think you'd almost, but it's up to you. You don't have to. I can see the look on your face.

Patient: No, I'm sort of...

Kate: Because one-on-one maybe with (exercise physiologist's name). When you're saying that you're muscle-wasting, she can work out stuff that you can do sitting in the chair with two cans of beans.

Patient: Yeah.

Kate: But how much do we do to help our muscles and that's where she's got all of that expertise for what really helps. Would you like me to send her a referral or not? Or do you want to see how you go?

Patient: Let me see how I go for the next month and if I can get myself organised, I'll be right. It's just a matter of getting used to it.

4. DISCUSSION

Limited previous literature has explored GPNs' lifestyle risk communication using the *exploring, guiding and choosing model* (Resnicow & McMaster, 2012). The GPNs' communication of relational aspects of lifestyle risk reduction in this study demonstrated both strengths and areas for enhancement. Maintaining rapport during consultations allowed GPNs scope to use communication strategies for understanding patients' risk factors and to consider potential interventions to address these, such as the barrier resolution and referrals that followed. The *exploring, guiding and choosing model* (Resnicow & McMaster, 2012) was a useful tool to identify these strengths, as well as missed opportunities for further exploration, agenda setting or education related to lifestyle risk. Hence, areas where GPNs can potentially be supported to up-skill can be focussed on as a result of this evidence.

4.1 Exploring

Following initial rapport building, GPNs explored lifestyle risk as part of routine CDM consultations using open-ended questions and listening. Listening was demonstrated through content reflections, or paraphrasing – an effective means of gathering information and building further rapport (James, McInnes, et al., 2020; Resnicow & McMaster, 2012). Reflections are more effective than questions in supporting patient views and choices and encouraging patient information sharing, although content and tone need to mirror the

patients' dialogue (Dobber et al., 2019; Polcin et al., 2015; Resnicow & McMaster, 2012). However, double sided reflections, not demonstrated in this study, help focus discussion and explore ambivalence by rationalising reasons for and against changing behaviour (Resnicow & McMaster, 2012). This can be achieved through empathy, facilitation of patient change talk and preparation of patients for potential problems in lifestyle risk reduction (Apodaca et al., 2016; Dobber et al., 2019; Polcin et al., 2015; Resnicow & McMaster, 2012). The use of this technique might have added value in some of the consultations.

Other techniques such as establishing a collaborative, or equal relationship approach when determining the agenda for change are known to support patient autonomy and engagement in the likelihood of lifestyle change (Moyers, 2014). However, GPNs in this study followed the kind of GPN question/patient response format that has been demonstrated in previous studies examining consultations (Östlund, Kristofferzon, Häggström, & Wadensten, 2015; Polcin et al., 2015; Pollak, Childers, & Arnold, 2011). This non-collaborative approach is aligned to the CDM remuneration structure or GPNs' agenda, rather than the patients'. Other barriers to supporting collaborative approaches to behaviour change is the ad hoc nature of GPN professional development in the communication of lifestyle risk reduction, time and a lack of organisational support (Halcomb, Meadley, & Streeter, 2009; Östlund, Wadensten, et al., 2015; Sonntag et al., 2012).

4.2 Guiding

GPNs' relational continuity with patients places them in an ideal position to monitor and guide lifestyle risk discussions over time (James, McInnes, et al., 2020). Effective communication about lifestyle risk also depends on patients' readiness to do so (Rollnick, Kinnersley, & Stott, 1993). For example, a patient at the pre-contemplation stage may be offered educational information regarding lifestyle guidelines rather than discussing action planning (Rollnick et al., 1993). GPNs in this study demonstrated the use of lifestyle

guideline education as a means of motivating patients for change. However, directive approaches, giving advice and generic health messages, such as lifestyle guidelines, can be resisted by patients and reduce the likelihood of lifestyle risk reduction (Östlund, Kristofferzon, et al., 2015; Rollnick & Miller, 1995). Instead, ascertaining patient readiness through using ‘confidence and importance scales’ or an ‘elicit-provide-elicited framework’ helps individuals to process and verbalise information in a personally applicable way (Resnicow & McMaster, 2012). Following this, summarising patient priorities and choices for lifestyle risk reduction, whilst requiring effort, demonstrates the GPNs’ listening skills and clarifies understanding (Mason & Butler, 2010; Sonntag et al., 2012).

4.3 Choosing

Where GPNs demonstrated goal setting, this was based on assessment and discussion during the consultation and involved content reflections, suggestions and barrier resolution. When lifestyle related goal setting is limited, it may be due to competing clinical priorities, referrals to allied health practitioners for this task, lack of GPNs’ skills in goal setting, or patient readiness for behaviour change. In our study, when GPNs used open-ended questions to explore patient strategies for meeting lifestyle goals, this facilitated commitment talk. To explore and affirm patient choices about lifestyle risk reduction options and to progress patients from talk about sustaining existing behaviours to change talk, further use of open-ended questions and reflections needs to occur (Östlund et al., 2016; Rollnick, Miller, & Butler, 2007). These strategies would provide relational support, understand patient perceptions and experiences as well as promote autonomy, commitment language and outcomes in behaviour change (Hardcastle, Fortier, Blake, & Hagger, 2017; Östlund et al., 2016; Rollnick et al., 2007).

4.4 Limitations

It is possible that only those general practices, GPNs and patients actively engaged in lifestyle risk prevention or CDM were willing to be video recorded than those who were not. Given the nature of qualitative research and data volume, analysis was limited to a subset of consultations where lifestyle risk factors were discussed. Concerns about selection bias in the study have been mitigated through the selection of representative GPN-Patient lifestyle risk consultations. Additionally, consultations were not dedicated to MI and while rapport building was identified in the data, additional rapport building activities might have taken place prior to the start of the video-recorded consultation. Further research could explore patient techniques during conversations with GPNs about lifestyle risk as well as patient outcomes following these.

5. CONCLUSION

GPNs are ideally placed to support reductions in chronic disease through discussions about lifestyle risk factors with patients. This study provides unique insights into using MI by GPNs. The GPNs' showed skills supporting relational aspects of MI such as open-ended questions, affirmation, content reflections and emotional support. Developing and leveraging these skills alongside implementing other strategies that were seen less often, including collaboration in agenda and goal-setting, double-sided reflections, summarising, an 'elicit-provide-elicit' approach and use of 'importance and confidence scales' would better support patients in lifestyle risk reduction. Our findings indicate that the GPNs in this study would benefit from further professional and skill development related to these aspects of lifestyle risk communication.

ACKNOWLEDGEMENTS

The authors would like to thank the patients, GPNs and practices who participated in the study.

Conflict of Interest statement

No conflict of interest has been declared by the authors.

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