2012

The retention of rural practice nurses

Kathryn Godwin

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The Retention of Rural Practice Nurses

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RN, A&E Cert, BHSc (Nursing), Grad Cert (Nursing)

This thesis is presented as part of the requirements for the award of the degree
Master of Nursing – Research of the University of Wollongong
School of Nursing, Midwifery and Indigenous Health

November 2012
Declaration of Authorship

Authorship Acknowledgment

Declaration of Authorship

Authorship Acknowledgment Form

Title of publication: The Detection of e-Orchestrina

Type of publication: Thesis

Proposed order of authors for this publication:

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Details of substantial intellectual contributions:

I have made the following substantial intellectual contributions to this publication:

Author 1: 

Author 2: 

Author 3: 

Author 4: 

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Abstract

This study has been conducted to explore the issues affecting the recruitment and retention of nurses in the rural general practice setting. There is a lack of qualitative research about the rural practice nurse role and why rural practice nurses remain in the Australian primary healthcare workforce. Commonly, research in this area has been characterised by the role of urban practice nurses, the role and retention issues of rural community and hospital nurses and workforce retention issues for rural health practitioners. This is the first study conducted solely on rural practice nurses in Australia, and seeks to capture three key objectives: to investigate why rural practice nurses remain in their role, to identify social aspects that effect rural practice nurse retention, and to identify professional aspects that effect practice nurse retention.

Semi-structured interviews were conducted with a purposive and convenience sample of rural practice nurses working in communities on the south coast of New South Wales in 2008. Data saturation was attained after seven interviews. Thematic analysis of the transcribed interviews was conducted using the NVivo 7 software package to organise data. The four main themes that emerged were the pursuit for professional recognition, grooming nursing services to meet needs, being ‘good for business’ (making money), and mastering the art of living.

This study is a starting point to understand the role of rural Australian practice nurses, and has provided an insight into the personal and professional life journey of rural practice nursing. The most satisfying aspects of the role were when nurses felt professionally trusted and respected, had designated nursing space and could achieve a life-work balance. The most challenging aspects of the role were moulding their nursing services within parameters of changing financial incentive programs, and the need for greater education opportunities to support the evolving generalist role. The nurses felt they needed to be professionally valued with greater remuneration. With changing primary healthcare policy incorporating the expansion of the practice nurse role, strategic support planning for the rural practice nurse workforce is essential.
Acknowledgements

I wish to thank the following people.

My supervisors Dr Janette Curtis, Principal Fellow, Associate Professor, School of Nursing Midwifery and Indigenous Health, Faculty of Health and Behavioural Sciences, University of Wollongong and Ms Yvonne White, Senior Lecturer - Renal Stream, School of Health, Faculty of Engineering, Health, Science and Environment, Charles Darwin University (formerly Senior Lecturer, University of Wollongong), for their dedicated support and guidance throughout this academic journey.

Professor Patrick Crookes, Dean, Faculty of Health and Behavioural Sciences, University of Wollongong for providing supervisory support in the early stages of this research project.

The rural practice nurse participants for their enthusiastic support of this project, and for generously giving up precious time to participate in this research.

The Australian Practice Nurses Association for the provision of financial support through the 2007 Postgraduate Scholarship Scheme, and the encouragement to publish findings from this project.

Professor Pat Bazeley for comprehensive NVivo 7 computer software instruction, patience and support with qualitative data analysis of this project.

General Practice New South Wales for their support, especially practice nurse program coordinator Ms Teresa Matheson (retired), in providing local resources to support this project.

Ms Marie Johnson for a professional transcription service that was carefully undertaken in an accurate and timely manner.
Dedication

I would like to dedicate this thesis to my gorgeous family, my husband Lance and my two daughters, Maddy and Nicole. I would also like to dedicate this thesis to all of those whose lives continue to inspire me from the past and present; my family, my community, my colleagues, my friends and patients.
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<tr>
<td>ACRRM</td>
<td>Australian College of Rural and Remote Medicine</td>
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<td>ADGP</td>
<td>Australian Divisions of General Practice</td>
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<tr>
<td>AGPN</td>
<td>Australian General Practice Network</td>
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<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<td>ANF</td>
<td>Australian Nursing Federation</td>
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<td>APNA</td>
<td>Australian Practice Nurses Association</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
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<tr>
<td>DoHA or “the Department”</td>
<td>Department of Health and Ageing</td>
</tr>
<tr>
<td>Division</td>
<td>Division of General Practice</td>
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<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>MBS</td>
<td>Medicare Benefits Schedule</td>
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<td>NHHRC</td>
<td>National Health and Hospitals Reform Commission</td>
</tr>
<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
</tr>
<tr>
<td>NRHA</td>
<td>National Rural Health Alliance</td>
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<tr>
<td>NiGP</td>
<td>Nursing in General Practice</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>PIP</td>
<td>Practice Incentives Program</td>
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<tr>
<td>RACGP</td>
<td>Royal Australian College of General Practitioners</td>
</tr>
<tr>
<td>RCNA</td>
<td>Royal College of Nursing Australia</td>
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<tr>
<td>RN</td>
<td>Registered Nurse</td>
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<tr>
<td>RRMA</td>
<td>Rural, Remote and Metropolitan Areas</td>
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<td>UOW</td>
<td>University of Wollongong</td>
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Glossary of Terms

**Block funding**
From January 2012 the Practice Nurse Incentive Program (PNIP) provides funding from Medicare Australia to practices/services that employ either practice nurses or Aboriginal Health Workers (AHWs) or both. The change in funding structure is to provide more freedom in the range of activities that can be undertaken and provides the opportunity for practice nurses to work to their full scope, releasing them of a cost reimbursement funding structure that renumerated particular clinical practice and tasks associated with item numbers. APNA (2012) supported this shift to block funding arrangement as it was seen to enable nurses to undertake a more varied role, and thus be engaged differently in meeting the clinical and financial demands on the practice.

**Chronic Disease Management (CDM)**
Planned care management and self-management strategies provided to those with a chronic illness, funded by Medicare for general practice services with or without the collaboration of other health related providers/services.

**District of Workforce Shortage (DWS)**
A district of workforce shortage (DWS) is an area of Australia in which the health needs of the population are not met by healthcare services and, therefore, the Australian Government has determined there is less access to medical services than the national average.

**Gap payments**
The Medicare Benefits Schedule fee is a fee for service set by the Australian Government. Where practices do not bulk bill services to Medicare there may be a gap amount to be paid as an expense by the patient. This gap amount is the difference between the Medicare benefit and the schedule fee.
Medicare Benefits Schedule (MBS)
The payment schedule delivered for health related services managed by the Department of Health and Ageing and administered by Medicare Australia. These payments provide the majority of funding for general practice services.

Peer review
Peer review is a process that publishers use to ensure a journal article is relevant, appropriate and of quality in the related field. The editors use a rigorous process to ensure the articles they publish represent the best scholarship currently available by seeking the opinion of scholars in the same field.

Practice Incentives Program (PIP)
The majority of payments made through the PIP are to practices and focus on aspects of general practice that contribute to quality care. These are made in additional to MBS items. Incentives are paid when the practice is accredited and has met set targets in order to gain eligibility for additional payments from the Department of Health and Ageing. This includes prescribing compliance, diabetes care, asthma, cervical screening, Indigenous healthcare, ehealth systems, practice nurse employment and after hours care that enhances the quality of services provided.

Practice Nurse Incentive Program (PNIP)
This provides additional funding to MBS items to practices that employ a practice nurse or allied health worker, for the minimum number of sessions per week over the payment quarter. The payments are greater for rural and remote practices are those located in Rural, Remote and Metropolitan Areas (RRMA) three (3) to seven (7). Urban practices are those located in RRMA one (1) and two (2).

Rural, Remote and Metropolitan Areas (RRMA)
This classification was developed in 1994 by the Department of Primary Industries and Energy (since known as Department of Human Services and Health and currently Department of Health and Ageing). The classification of rural areas uses personal distance related to population density and indicates the 'remoteness' or average distance of residents from one
another. This classification is currently under review by the Department of Health and Ageing.
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1. Introduction

Background to the study

In 2002 new Australian Government health initiatives focused on improving the delivery of primary healthcare particularly in rural and remote areas. Many general practitioners (GPs) responded to Department of Health and Ageing recruitment for urban and overseas trained doctors to work in rural areas of need with financial incentives to increase the rural GP workforce shortages. In some area, however, recruitment did not meet the increased healthcare demand and practice nurses were needed to support the general practice workforce, supported by the Nursing in General Practice (NiGP) Initiative (DoHA 2002). It was with great enthusiasm that I took up the challenge of nursing in a practice with a solo GP within my rural community nearly ten years ago.

Over the last nine years the practice nurse workforce has grown, particularly in rural areas across Australia. In 2008, the Australian Practice Nurses Association (APNA) estimated there were over 8,000 practice nurses, with at least 60% of general practices employing at least one practice nurse (APNA 2008). Practice nurses provide a wide range of services, particularly with clients with high care needs including ageing clients and those with complex and chronic disease. In Australia, practice nursing has emerged as a key component in primary healthcare with one nurse to every 2.3 GPs in 2007 (AGPN 2007).

To address the inefficiency and poorer health outcomes in rural and remote areas, the findings of the National Health and Hospitals Reform Commission final report, *A healthier future for all Australians* (NHHRC 2009, p. 219), identifies the importance of building a quality interdisciplinary workforce. Now that rural practice nurses have been integrated into general practice to support workforce shortages, the important issue is how to retain rural practice nurses in order to make rural primary healthcare sustainable.

This study has been conducted as a starting point to understand the role of the Australian rural practice nurse. The primary purpose of this study is to explore the social and
professional impact of the role to provide insight that will contribute to the contemporary discussion of how to recruit and retain practice nurses.

**Aims of the study**

This study has three objectives: to investigate the reasons why rural practice nurses remain in their role, to identify the social aspects that effect rural practice nurse retention and to identify professional aspects that effect rural practice nurse retention.

All practice nurses within a rural Division of General Practice were invited to participate in the study and by taking part in a face to face interview with the researcher. Interviews were conducted from 13 November 2008 to 6 March 2009. Data saturation was attained after seven practice nurses were interviewed. At this stage the interviews revealed close similarities and repetition of themes so further participant recruitment was deemed to be of no benefit. In the thematic analysis of data, similar responses were categorised into sub-themes and from which emerged key themes. As data saturation had been determined, it was decided to further refine the data analysis and complete the study at this time.

**Recruitment**

Twenty-two practice nurses responded to the invitation for face to face interview. All of the practice nurses came from a general practice in a rural area with a Rural, Remote and Metropolitan Area (RRMA) index of four (4) which means the area has a small rural centre with a low availability of health services when compared to metropolitan areas (DPIE 1994). Geographically, the majority of participants work approximately 30 minutes away from the central business district, in small coastal villages. The rural area in this study is deemed to be an ‘area of need’ due to the workforce shortage of general practitioners in the region. The economic base for this rural area is agriculture (predominantly beef and dairy), fishing, tourism and defence services.

All participants were registered nurses and worked in a variety of contexts, from solo GP to multidisciplinary general practice clinics, and the responses from these participants captured the diversity of rural general practice roles. The participants had been working in general
practice for between one and 18 years and most had young families. Roles incorporated advanced nursing care including providing emergency care, extended care encompassing client support and chronic disease management, and generic nursing tasks such as wound care.

The themes

The themes emerged from sub-themes collated from responses. Themes were analysed and related to both social and professional satisfaction in the respondents. The four main themes were: the pursuit for professional recognition, grooming nursing services to meet needs, being ‘good for business’ (making money) and mastering the art of living.

The first theme, the pursuit for professional recognition, describes the professional journey participants had experienced from first starting practice nursing to the time of the interview. The participants described how they had to “plough through” to integrate their role into the practice in order to attain satisfying levels of professional recognition, acceptance and respect from both GPs and patients.

The second theme, grooming nursing services to meet practice needs, describes the readiness of the nurse to undertake the diverse generalist role of a practice nurse despite being unprepared, having worked previously in a different healthcare setting. As the individual practice nurse evolved into the role, professional competence and confidence from both previous and new experience and education enabled the nurse to groom their role to suit the needs of the general practice. Significantly, the role requires greater clinical decision making which came from working in environments described as a “mini emergency department-like” treatment rooms and providing nurse-led initiation for preventative healthcare in private consultation (such as Pap tests and immunisation clinics). The majority of participants felt they needed to extend their knowledge and skills to perform tasks competently, and expressed the frustration and difficulties in accessing adequate education and training due to the lack of GP support, cost, distance and time away from family.

The third theme, being ‘good for business’ (making money), describes how the participants tried to maintain their professional integrity in order to deliver a high quality nursing service, within a financially efficient framework. In order to provide efficient care, the participants
needed to be supported with adequate nursing spaces in the practice infrastructure. Where nurses shared nursing spaces with other health professionals they felt ‘devalued’.

The fourth theme, mastering the art of living, links to the satisfaction of the participants attaining a life-work balance. Most participants had children living at home and described great satisfaction with the practice nurse job fitting in with family commitments and the rural coastal lifestyle. The majority had previously worked in a rural area and/or had a childhood in a rural area, feeling satisfied that they had always belonged. Participants from urban and regional areas described how it was important to develop professional relationships to be accepted and trusted by the community in which they work.

**Research findings overview**

The findings from this study reflect a rapidly growing and challenging area of rural clinical practice. This study seeks exploration and understanding of the social and professional aspects of the practice nurse generalist role. Clearly the role has emerged and evolved amongst the reactive funding changes to the general practice business, particularly from Medicare-funded primary healthcare reform initiatives and the growth in extended general practice services that these rural practice nurses offer.

The findings of this study identify that rural practice nurses feel satisfied when they are respected and trusted by GPs and patients, given greater support and access to relevant education and training for the development of new skills, the provision of enhanced facility infrastructure, particularly for emergency treatment and private consultation, and when they feel professionally valued with equitable remuneration. The future of the practice nurse workforce needs to be supported in order to remain sustainable throughout the growth in general practice services as we adapt to growing healthcare needs, particularly in chronic disease care in rural communities.

**Structure of the thesis**
This thesis describes the explorative study into the social and professional issues that effect retention of rural practice nurses. This thesis is a classical structure with introduction, literature review, method, results and discussion and conclusion. This introductory chapter has provided an overview of the thesis with a background to the study, significance of the study, objectives of the research, the recruitment process and overview of thematic analysis, the research findings and discussion and conclusion.

The literature review is an extensive appraisal and discussion of previous research relevant to the topic. It outlines what is known about the social and professional issues that may effect the recruitment and retention of practice nurses, rural nurses and rural healthcare workers. The literature review provides key themes that evidence why this study is important. The literature identifies that rural areas have health workforce shortages, especially general practitioners and the 2002 NiGP Initiative was introduced to support the rural and remote general practice workforce. The literature review findings identify that the need to support practice nurses with skills, knowledge, infrastructure, career structure and remuneration is essential in order for nurses to sustainably support communities and the general practice business.

The third section details why a qualitative study was chosen, the development of the semi-structured interview tool, recruitment, data collection with interviews and transcripts, interpretation of data and thematic analysis with NVivo 7 software analysis tool, and the ethical considerations, credibility, dependability and transferability of the research.

The fourth chapter, encompassing results and discussion, considers the explorative findings of data extracted from semi-structured interviews with rural practice nurses. This chapter compares the attributes of the participants against the practice nurses of Australia. Four key themes emerged from the data and are discussed in this chapter: the pursuit for professional recognition, grooming the role to meet practice needs, being ‘good for business’ (making money), and mastering the art of living. These themes are discussed in relation to the literature findings.

The conclusion provides an overview of the study findings and how this first Australian study on rural practice nurses significantly contributes to the body of research on practice nursing
in Australia. The recommendations provide insight into the role of the rural practice nurse, clinical support issues and future nursing research. Further, the conclusion reflects on how the rural practice nurse can be supported socially and professionally, which can positively impact job satisfaction in the rural primary care workforce. The findings of this study allude to areas of clinical practice where greater support is needed for nurses to sustainably support the GP workforce and general practice business, to attain and maintain safe delivery of primary healthcare to rural communities. This final chapter also describes the limitations, dependability and adequacy of this study.
2. Literature Review

Introduction

An extensive literature review was conducted to investigate what was already known about the recruitment and retention of rural practice nurses in Australia. This chapter describes the search strategies used, together with the key findings of the literature review. Articles that provided background information and insight into issues that could and did effect the recruitment and retention of rural practice nurses up to the beginning of the study in 2008 were grouped into themes. The literature review findings provided information of past and current developments in the field of rural practice nursing and insight into the application of qualitative research methodology. Whilst there was little literature to identify issues directly related to the retention of rural practice nurses, the review added depth to the researcher’s existing knowledge, especially on the strategic direction of government policy associated with the evolution of primary healthcare nursing in Australia. Conclusions drawn from the literature review demonstrated a lack of information in relation to the rural practice nurse role and, therefore, explorative research was required to understand this role in general practice.

This chapter is structured into three key components. First, the search strategy will incorporate the books, journals and websites used for the review. Secondly, the four key themes will be introduced and described in relation to rural practice nurse recruitment and retention in Australia. The final section is a summary of the methodologies used in the research projects and an overview of the implications of the findings for future practice, education and research gaps. In 2008, the Australian General Practice Network (AGPN) National Practice Nurse Workforce Survey (AGPN 2008) reported that there were over 8,000 practice nurses in more than an estimated 60% of general practices in Australia, however, the rural workforce component is unknown. Conclusions drawn from this literature review demonstrate that exploration to understand the role of the rural practice nurse is needed to provide strategic insight for future retention of the rural practice nurse workforce.
Search strategy

A search strategy is used to rigorously and thoroughly search books, journals and government websites for information on topics related to rural practice nurse retention (Hibbert 2006). A consultation of the search strategy terms was undertaken with the University of Wollongong (UOW) Health and Behavioural Sciences Faculty librarian, commencing with a broad literature search using key words, phrases and truncations which maximised the search field. Key terms used were: practice nurse retention, nurse retention, Australian rural nurses, rural, general practice, general practice nursing, rural nurse satisfaction, Australian nurse retention, rural nurses, community nurse retention, nursing workforce issues Australia, and rural health.

The databases searched through the University of Wollongong library were: CINAHL, SAGE, MEDLINE, ProQuest5000, Expanded Academic ASAP and Meditext.

The initial search criteria included articles less than ten years old and due to only a small number of articles yielded (12 articles), the search was expanded to incorporate rural Australian nurses and healthcare workers, targeting articles related to retention of staff and workforce issues. The search was then expanded further to elicit articles less than ten years old from the United Kingdom (UK) as it became evident that the development of the practice nurse profession evolved from the National Health Service (NHS) in the UK. National sources and Australian Government websites were accessed, from the Australian Practice Nurses Association (APNA), Australian Divisions of General Practice (ADGP), Australian General Practice Network (AGPN), Australian Medical Association (AMA) and the Australian Nursing Federation (ANF), as all of these organisations have published literature on practice nursing policy development. All journal articles used in this review have been peer reviewed.

The results of the searches retrieved a total of 367 articles of which a total of 127 were relevant to the research topic. The articles selected for inclusion in this literature review were articles related to rural workforce recruitment and retention, job satisfaction, practice nurse roles, Australian Government primary healthcare policy, and articles related to roles and expectation of rural community health workers and general practice nurses in Australia. Articles that were related to urban hospital settings exclusively were excluded as they were not relevant to the rural context. There were four major themes that emerged from the
literature that are related to both the rural healthcare workforce and the practice nurse workforce.

Key Themes

This literature review has been arranged into four major themes which were found from the search of the literature. These themes are identified as: nursing in the rural context, the integration of nursing into general practice in Australia, practice competency, and practice nurse support. The first theme, nursing in the rural context, relates to primary healthcare needs in the rural context, and the issues effecting the rural health workforce, especially rural nurses. The second theme, the integration of nursing into general practice in Australia, describes the evolution of practice nursing in general practice and the role of the practice nurse. The third theme, practice competency, discusses the preparedness of practice nurses for their role and provides evidence of the effects that the dynamic role of the practice nurse has on the needs of ongoing education and training for nurses to maintain clinical competency. The fourth theme, practice nurse support, discusses the problems for practice nurses such as insufficient remuneration and an overview of the financial support structure for practice nurses including limitations associated with the Medicare billing structure.

Key Theme One: Nursing in the rural context

Nursing in the rural context is divided into two main sub-themes, defining rural health in Australia and recruitment and retention of the rural health workforce. These sub-themes provide a background insight into the healthcare workforce shortage in rural Australia. This theme analyses the healthcare challenges that need to be addressed to meet the needs of the rural population, and the social and professional issues that effect the retention of the healthcare workers in Australian rural communities.

Defining rural health in Australia

The hallmark of Australia’s current system for defining urban, rural or remote status was introduced in 1966 with the first nationwide census, which was based on population density.
The system became more complex as our population grew. Infrastructure such as major highways linked the eastern coastline of Australia whilst other regional areas, some mining and industrial centres, saw a decline in population numbers (Hugo 2002). By 1991 spatial patterns of evidence gathered by census for determining accessibility and population changes were then related to demographic population growth in individual country areas against metropolitan areas (Hugo 2002, p. 17). In 1991, the main population factors studied by the Australian Institute of Health and Welfare (AIHW) related to health – fertility (the child birth rate), mortality (the patterns of death), internal migration (areas the Australian population moved to) and international migration (migrants from overseas and Australians leaving to live overseas) – were linked to geographical populations (Hugo 2002). The Rural, Remote and Metropolitan Areas (RRMA) classification was introduced in 1994 by the Department of Primary Industries and Energy (DPIE 1994, p. 1) “in response to the growing need for knowledge and information about issues of concern in rural and remote Australia” for the provision of goods and services, including healthcare services, and was based on population size, density and distance. The term rural is incorporated within the non-metropolitan zones, including large, small and other rural areas with populations from less than 10,000 up to 99,000 with a remoteness indicator of less than or equal to 10.5 (DPIE 1994, p. 1). In 2008, the AIHW report identified that 34% of Australians residing in rural areas are more likely to be Indigenous Australians and have a poorer health status when compared to Australians living in urban areas (AIHW 2008).

The poorer health status of rural Australians has not only been related to geographical location, but also to the lower socioeconomic status as rural income is predominantly from social welfare and lower paid, labour-intensive jobs such as farmers (AIHW 2008). Higher risk occupations, poorer nutritional status related to accessibility to fresh, low-cost foods, poorer lifestyle choices (increased alcohol consumption and cigarette smoking) and country roads associated with long distances and poor road surface conditions have also contributed to a lower health status in rural Australians (AIHW 2008). These are factors that contribute to a higher incidence of rural resident mortality risk for chronic diseases including an increase of 23% for coronary heart disease, an increase of 16% in vascular disease, an increase of 11% for chronic obstructive airways disease (COAD), as well as higher rates of diabetes, suicide and cancer rates for prostate, colorectal and lung cancer (AIHW 2008).
The chronic disease risk factors and the lack of accessibility to healthcare services in rural areas increases rural mortality risk compared to urban areas. This lack of accessibility also impacts on the need for different nursing and medical roles when compared to urban primary healthcare practices as there are fewer services, greater distances to travel for specialist and allied healthcare, less choice in available services and a smaller healthcare workforce (Bourke et al. 2004). Compounding the lack of accessibility is the persistent difficulty in attracting and retaining health professionals to work outside urban areas (Larson 2002; Harding 2006).

The main provider of healthcare services in rural Australia is a generalist doctor or rural nurse (Hegney 2007). Many concerns have been expressed by doctors over the lack of general practitioners in rural areas (Hegney 2007; Hays et al. 1997). Access to health services in rural areas generally consists of a general practitioner with a small hospital offering differing levels of onsite and visiting allied healthcare and specialists (Hegney 2007). From the private general medical practice the majority of primary healthcare services are provided to the rural community. However, despite incentives such as training of registrars and financial support in general practice aimed at attracting doctors to rural areas where a shortage of GPs has been determined a district of workforce shortage (DWS), there continues to be an undersupply of rural general practitioners (Australian College of Rural and Remote Medicine (ACRRM) 2006). Whilst the majority of GPs are Australian trained and born, more than a third of rural GPs have been professionally trained overseas (Kamien 2004). With fewer resources available, rural health workers are more likely to work in an extended role, provide procedural care and be more reliant on other health professionals, especially rural nurses (Smith & Hays 2004).

When rural GP working hours are compared to their urban colleagues, rural GPs work 10% longer due to a higher patient load, which is compounded by the shortage of rural GPs (AIHW 2008). Studies of rural clients have found that they are less likely to see a GP for many reasons; rural clients focus on the curative approach rather than seek preventative care (Kamien 2004), rural clients are stoic in nature and more likely to put up with or ignore their symptoms (Humphreys et al. 1997), travel is costly with longer distances to travel (Humphreys et al. 1997) and there are longer waiting times for clients of rural GPs (Smith & Hays 2004).
Within rural communities there are significant cultural differences between the healthcare providers and clients: allied healthcare workers, doctors, Indigenous people, doctors who have migrated from different countries, and “the cocky farmers” they serve (Larson 2002, p. 58). The literature has identified that without understanding cultural differences one cannot understand the different employers and clients (Hegney 2007), however, it is unknown if the cultural differences impact on the rural practice nurse role.

The rural setting was found to be unique in a study of rural nurses, as the setting provided the opportunity for nurses to develop special relationships in the care of their clients from the cradle to the grave (Hegney et al. 2002b). In a cross-sectional mail survey of nurses who resigned from Queensland Health after working in rural and remote areas, Hegney et al. (2002b) studied the factors that influenced why the nurses chose to leave or remain in this area of nursing. The tool used by Hegney et al. (2002b) was a questionnaire that collected both qualitative and quantitative data. The Queensland Nursing Council conducted the mailout from a database of 443 nurses, of which there were 146 across 21 Health Service Districts. Most of the rural nurses studied had previous exposure to rural or remote life. Strong cultural/social networks, the sense of belonging to a community, and bringing up family with the rural lifestyle were identified as main positive characteristics of rural life for these nurses (Hegney et al. 2002b).

**Recruitment and retention of the rural nursing workforce**

Similar to other rural health professionals such as doctors (Hays et al. 1997) and pharmacists (Harding et al. 2004), registered nurses (Larson 2002; Witham 2000) are in short supply in many country areas. Larson identified that in rural hospitals enrolled nurses, who have often been trained locally, are perceived as a more stable workforce, and are often consciously used in a “trade-off” with registered nurse positions to ensure adequate staff levels by regional managers (Larson 2002, p.65). The national shortage of nurses (Department of Employment, Workplace Relations and Small Business (DEWRSB) 2000) has been problematic for at least 20 years in 2004 (Nowark & Bickley 2004), and recently the National Health and Hospitals Reform Commission (NHHRC, 2010) has sought opportunities to respond to workforce issues particularly in the primary healthcare setting. The NHHRC investigated opportunities to expand the role of nurses with suitable training and accreditation programs, particularly
where the nurse is the only provider for emergency services and primary healthcare in rural and remote communities (NHHRC 2009).

Socially, the attractions of the rural lifestyle for nurses, doctors and allied healthcare workers is cited in the literature, suggesting that the rural lifestyle offers a “comfortable, relaxed and safe family lifestyle, particularly for young children” (Hays, Veitch, Cheers and Crossland 1997, p. 199). Often strong bonds with the community are formed, with a community interdependence cited as a common experience of rural healthcare workers who are entrenched in a ‘close knit’ rural community over a long period of time (Harding et al. 2006; Hegney et al. 2002b).

Rural nurses enjoy the diversity of the generalist role, greater autonomy, the challenging nature and greater scope of advanced practice (Hegney et al. 2002b). The enjoyment of a challenging and diverse role was also evident in other studies of rural nurses by Witham (2000), Gibb et al. (2005) and Stragnitti et al. (2005). Factors that make rural practice more inviting are: more career progression opportunities for the nurse, increased employment opportunities for their partner and easier access to family-friendly child care facilities for hospital shift work (Hegney et al. 2002b).

However, the diversity of rural nursing is in itself often seen as a “double-edged sword”; along with the diversity of patient care comes the need to perform procedures for which they are not necessary qualified nor trained (Larson 2002, pp. 66-67). Tasks expected of rural nurses often include “prescription, administration or altering of medication, insertion of intravenous lines and suturing wounds” (Witham 2000, p. 19). The literature reported that job dissatisfaction amongst rural nurses is often compounded by the lack of back-up and professional support from medical practitioners (Larson 2002), inadequate telecommunications (Larson 2002), lack of time with work pressures and stress (Witham 2000), lack of staff leave replacement arrangements (Witham 2000) and insufficient access to education and training (Larson 2002; Witham 2000). Professionally, the nurses who had resigned from Queensland Health after working in rural and remote areas found career progression was difficult to attain, due to low turnover of senior staff, and difficulty to access training for promotion (Hegney et al. 2002b).
Reduced quality of life for rural GPs was found in two qualitative studies investigating GP retention. These studies found that issues such as lack of social and cultural facilities, inadequate educational facilities particularly for secondary children, and remoteness from family and friends, significantly impacted on their intention to leave (Alexander 1998; Hays et al. 1997).

Loss of anonymity, particularly living and working in the same community, contributed to the reduction in the retention of healthcare workers. The literature identified that belonging to the community was problematic, as it meant that everyone, including healthcare workers, had little if any anonymity (Harding et al. 2006; Hegney et al. 2002c; Hays et al. 1997). In a qualitative study that explored why doctors leave rural practice, interviews conducted at least three months post resignation found that a “close and special relationship” with the community often compromised the clinical work causing the GPs to feel “too attached” and lose clinical objectivity (Hays et al. 1997, p. 200). The emotional ties with the community made it difficult for the doctors to be away from work (Hays et al. 1997). The emotional demands of rural client relationships has also been the major determinant of rural Australian nurse resignation (Hegney et al. 2002c).

Interpersonal conflict has been linked with job dissatisfaction and resignation in rural community nurses (Hegney et al. 2002c) and doctors (Hays et al. 1997). Personality clashes that developed with significant community leaders such as senior nursing staff, other doctors, health managers and local government leaders lead to the decision to resign (Hays et al. 1997). The close nature of the workplace made it difficult for the doctors to deal with the personality of “powerful but unavoidable individuals”, and reduced job satisfaction in rural GPs (Hays et al. 1997, p. 200).

The factors that effected the recruitment and retention of pharmacists to practice in rural and remote areas of New South Wales was explored by Harding, Whitehead, Aslani and Chen (2006) with qualitative semi-structured interviews with a purposive sample of 12 community pharmacists. Important recruitment factors for the pharmacists were: they had previously lived in a rural area, greater availability of better business opportunities and economic factors such as low cost housing and competitive service costs. However, the detractions included the limited access to continuing professional development (CPD) as this was seen to be
Key Theme Two: The integration of nurses into general practice in Australia

This theme provides an overview of the historical perspective of the integration of practice nurses into general practice in Australia since their recruitment following the NiGP Initiative (DoHA 2002). Since the inception of the program in 2002, the practice nurse role has been evolving, as nurses have adapted to primary health promotion and prevention programs introduced to general practice by the Australian Government. The practice nurse workforce has seen tremendous growth since the NiGP Initiative, and nearly half of practice nurses are thought to work in rural areas where there are GP workforce shortages. However, the practice nurse workforce is older than the Australian nurse workforce, with many approaching retirement (AGPN 2007).

Primary healthcare in Australia

Global recognition of Primary Health Care (PHC) was formalised in 1978 by the World Health Organisation (WHO) with the Declaration of Alma-Ata (WHO 1978). This was seen as the key to achieving “Health for All by the Year 2000” worldwide, through treatment and disease prevention, encompassing health service collaboration and multidisciplinary partnerships with communities (WHO 1978). By 1990, the Australian Department of Health and Ageing (DoHA 1990) formulated a National Health Strategy which focused on the pivotal role of general practice in primary healthcare. In 2001-2002, a Commonwealth budget of $104.3 million was allocated to the NiGP Incentives Program which encouraged GPs, particularly those working in rural and remote areas, to employ practice nurses and expand the role of nurses into a primary healthcare role that was to be complementary to the GPs role (DoHA & Royal College of Nursing Australia (RCNA) 2001). Practice Incentives Program (PIP) payments were made by Medicare to general practitioners from 1998, initially to compensate for the high volume, brief consultations associated with chronic diseases. This was expanded in 2002 to incorporate other specific areas: information technology software, after hours care, medical student teaching, better prescribing and clinical initiatives including
the employment of practice nurses in rural areas (Healthcare Management Advisors (HMA) 2005).

The practice nurse role

The term ‘practice nurse’ refers to a registered nurse or enrolled nurse who is employed by, or whose services are otherwise retained by, general practice (DoHA 2006). Practice nursing in Australia has evolved substantially since 2002 when Australian Government policy promoted the NiGP Initiative to relieve GP workforce pressure, “During the past five years, there has been an even greater focus on the valuable and diverse roles that nurses can play in supporting GPs in the provision of primary care services” (AGPN 2009, p. 9). In 2002, the Department and the RCNA set formal guidelines around the practice nurse role, for prospective practice nurses and employees in private general practice businesses (DoHA & RCNA 2002). The practice nurse role is diverse and encompasses patient, carer and community health promotion and education activities, a contribution to improved and sustainable practice management with human and material resources, and a contribution to the enhancement of the management and prevention of ill-health (DoHA & RCNA 2002). Initially in 2002, the nurses’ role was focused on the introduction of enhanced primary care (EPC) programs, which entailed care planning and monitoring of clients with known chronic disease with a focus on health promotion and self-management strategies. In 2003, there was additional funding to the PIP scheme, Medicare rebates allocated to underserved urban areas, and the generation of expanded Medicare Benefit Schedule (MBS) item numbers for practice nurse immunisation and wound care management.

The evolving role of the practice nurse was reported in a literature review of three studies conducted by Patterson (Patterson et al. 2005). The practice nurse was found to have a diverse generalist role expectation in preventative health. In primary prevention roles, the nurses provided immunisation and lifestyle education with advice on smoking, diet, exercise and stress reduction with associated education materials such as pamphlets (Patterson et al. 2005). There was little secondary disease screening described by practice nurses in this research. In tertiary disease care, practice nurses contributed to educating and monitoring patients with chronic and complex disease states such as diabetes, asthma, and/or cardiovascular disease. Often these roles were conducted whilst undertaking a medically allocated task such as wound dressing, blood pressure check or spirometry. Overall, the
practice nurse role was found by Patterson et al. (2005, p. 49) to have “clinical, educative, administrative and supportive components” in the general practice setting and suggests there may be a difference between the primary healthcare role of the practice nurse in rural and remote areas to that of an urban practice nurse, however, to date there have been no known studies which have reported similarities and differences.

*Rural* practice nurses are expected by consumers to have a greater role in triaging patients who arrive unexpectedly and provide emergency care (Cheek et al. 2002), whilst health assessments and care planning tasks are fewer than the numbers undertaken by urban practice nurses (Cheek et al. 2002). This is most likely related to lack of accessible emergency hospital services due to remoteness. In 2007, the characteristics of nurses working in Australian general practice were investigated by Joyce & Piterman (2009) who describe the backgrounds, working environments, tasks and duties of practice nurses working in all regions of Australia. The roles of all nurses involved direct patient care, with 90% of these nurses also required to be actively engaged in practice management and administrative tasks, and 57% of the nurses required to undertake receptionist and secretarial duties if needed. The wide variety of practice nurse tasks was found not to relate to years of experience, remuneration or setting by the researchers (Joyce & Piterman 2009). Current literature supports the need for role clarification within a career framework, as this was found to be an important factor for practice nurse recruitment, retention and job satisfaction (Joyce & Piterman 2009; Kelleher et al. 2007; Halcomb et al. 2006).

**The practice nurse workforce**

In 2008, the AGPN practice nurse workforce survey (AGPN 2008) reported that there were over 8,000 practice nurses in more than an estimated 60% of general practices in Australia. The review of the workforce incorporated age, gender, hours worked and educational standards for practice nurses. As there are no statistics collated in workforce surveys specifically on *rural* practice nurses in 2008, it is not possible to ascertain the demographical information and workforce demands on practice nurses working in rural areas at the time of this study.

The age group of practice nurses is particularly important to review, as this can influence not only the need to recruit nurses as older nurses retire, it can also influence other factors to
support the retention of practice nurses, such as accessible and relevant education opportunities, family commitments and the need for child care. The AGPN (2007) survey identified that 78% of practice nurses are over 40 years, with 35% of registered practice nurses and 20% of enrolled practice nurse found to be between 50-59 years of age, with an average age of 45.8 years. The practice nurse average age is older by almost three years when compared to the national nursing workforce of 43.1 years (AGPN 2007). These statistics evidence that the practice nurse workforce is ageing.

The majority of practice nurses are female (98.6%), registered nurses (79.4%) [as opposed to Enrolled Nurses] and work part-time (75%) as a practice nurse, with 30.7% of practice nurses working in another nursing position (AGPN 2007). There is no exploration of the reasons why the nurses needed to work a second position, however, this may be related to salary and conditions that in turn could impact on future retention of the practice nurse workforce (AGPN 2007). The AGPN study also identified that 20.13% had worked in general practice for less than one year with the majority (40.18%) having between two to five years experience, 19.58% between six to ten years and 20.13% having 11 or more years experience (AGPN 2007, p. 26). This indicates that the majority of practice nurses who participated in the AGPN (2007) workforce survey had been working in general practice since the introduction of the 2002 NiGP Initiative.

Geographically, nearly 45% of practice nurses work in a rural RRMA category of four (4) to seven (7) (AGPN, 2007). The RRMA classification reflects both the population density and the distance between services, with category four (4) denoting rural and category seven (7) denoting remoteness, with fewer people and the least availability of health services (DPIE 1994, np). The AGPN (2007) survey identified that the majority of practice nurses work in medium to large practices with two or more GPs, and that most practice nurses work with at least one other nurse (65.9%). However, rural nurses participating in an educational needs study were found to be more likely to work alone in medium sized practices of two to five GPs (Pascoe et al. 2005).

Most practice nurses have at least one additional graduate qualification (62.3%) (AGPN 2007) which demonstrates a significant rise compared to 17.8% in the 2005 AGPN survey data (AGPN 2007). The most frequently reported qualifications were: accredited nurse
immuniser (27.3%), midwifery (20%), women’s health nurse (11.1%) and asthma educator (7.2%) (AGPN 2007, p. 28). This suggests practice nurses perceive a need for further education and seek education courses specifically related to their practice nurse role.

Practice nurses’ dissatisfaction with remuneration is evident in the APNA Salary and Conditions Survey (APNA 2009). The survey identified that more than 60% of practice nurses working in the corporate sector are looking for a new position, or intended to in the next six months (APNA 2009). The average take-home pay for a practice nurse was $26.38 per hour, compared to a national average of $30.61 per hour without penalties for a registered nurse working the hospital setting (APNA 2009). Investigating the findings of this report and relating it to workforce retention raises concerns for the future sustainability of the practice nurse workforce.

**Preparedness for practice**

Practice nurses, by the nature of their general practice working environment in general practice, are found to be put into situations for which they are not always professionally prepared (Cross 2006; Meadley et al. 2004). Preparedness for the role is not necessarily a measure of qualification, nor something that can be measured in an interview, and is identified by Cross (2006, p. 71) as having “insufficient education” and “not necessarily having the expertise” for the general practice setting. Within Australia, GP expectation of the practice nurse role is found not to match the clinical competence of practice nurses due to evolving role expectations (Halcomb et al. 2005).

The rural nurse role in Australia has been referred to as an advanced nursing practice in a discourse analysis study conducted by Hegney between 1991 to 1994 (Hegney 1997). Hegney (1997) identifies that both hospital and community based rural nurses are often seen to be in a generalist role, as they are not known to work within one discrete area of practice. However, to practice competently and confidently, a wide range of skills and knowledge is necessary “to extend their role into the domain of medicine, pharmacy, radiography and other allied health discipline areas” (Hegney 1997, p. 23). This extended role was seen to “fill the gap”, as the nurse provides essential service to the community due to the inability of health services to employ a range of health professionals (Hegney 1997). It is the lack of support services in rural areas that is seen to influence the scope of practice of rural nurses, however,
Hegney (1997) identifies that not all rural nurses are confident in being accountable for their independent decisions.

Greater support for interdisciplinary practice for practice nurses is needed. For example, there is limited scope in practice nurse roles to provide for the burden of chronic cardiovascular disease (CVD) and there are significant barriers faced by general practice in providing CVD management (Halcomb, Davison, Yallop, Griffiths & Day 2007). This project is the third phase of a large project known as *Carving a niche for Australian practice nurses* (Halcomb et al. 2007). Whilst it was identified that practice nurses are potentially useful to provide nurse-led chronic disease support services for CVD management, there are significant barriers that need to be addressed by policy to make the practice nurse interventions sustainable (Halcomb et al. 2007). The barriers include funding issues, legislative regulation, intersectorial collaboration, professional regulation and competing health priorities (Halcomb et al. 2007). The role of the practice nurse needs to be formalised within the national practice nurse competency standards and generic practice nurse job descriptions (Halcomb et al. 2007).

Unpreparedness for nurses new to the practice nurse role is found to be related to job dissatisfaction (Cross 2006; Rosen & Mountford 2002). Whilst there are no studies on practice nurse-led clinics in Australia at the time of this literature review, there is a study conducted in the UK exploring the practice nurse role preparedness for walk-in clinics. Practice nurses participated in a qualitative study that explored their role in establishing nurse-coordinated walk-in centres in the UK. The study found there were no formal skills, knowledge or attributes required of the nurses that could prepare them for their role (Rosen & Mountford 2002). This study concluded that the most appropriate form of training and experience for nurses new to the role “was learned through apprenticeship, and was every bit as important as formal nursing education, much of which was more theoretical than practical” (Rosen & Mountford 2002, p. 246).

Emotional wellbeing was found to be related to a satisfying professional practice (Rose & Glass 2006). The authors researched community mental health nurses and found that emotional wellbeing and professional practice are linked to three components: being able to speak out (or not), being autonomous (or not) and being satisfied (or not). This research may have implications for rural practice nurses; often rural community nurses deal with
emotionally distressed friends and neighbours who are clients/colleagues and patients, which adds to an existing high workload that the nurse finds physically and psychologically stressful (Rose & Glass 2006; Hegney et al. 2002b). Rose & Glass (2006) found that in order to maintain a passion for nursing, nurses need ongoing organisational support in their autonomous roles. These authors recognise that without this support, not only is the emotional health of nurses jeopardised, it also has a negative effect on retention of nurses. In the hospital setting, a psychological contract between the employer and employee is identified in research as a subjective perception of a behavioural agreement that is not written (Chan et al. 2004). The authors found that when this perceived agreement is breached, a negative attitude elicits dissatisfaction, resentment, anger and mistrust, which inevitably results in the employee leaving (Chan et al. 2004). When emotional support is positive, nurses are more likely to stay (Chan et al. 2004).

One of the support structures for rural Australian nurse education that strongly emerges from the literature is mentorship (Dusmohamed & Guscott 1998; Croxon & Maginnis 2006; Pascoe et al. 2006; Mills et al. 2007; Mills et al. 2008). Mentoring is defined as “a one-to-one relationship between an experienced rural or remote healthcare professional (mentor) and a less experienced undergraduate student” (Mills et al. 2007, p. 394). Evidence of improved retention of staff through creating a mentoring climate of support and a culture of care, which in turn improves job satisfaction and morale, is identified by Mills et al. (2007).

**Meeting consumer expectations**

Consumer perceptions of the role of the practice nurse were explored by Cheek, Price, Dawson, Matt, Beilby & Wilkinson (2002), who capture the initial consumer perceptions of nurses and nursing in general practice as part of the National Steering Committee on Nursing in General Practice in 2002. Data were collected from 20 focus groups across Australia and a workshop with representatives from the Consumer Working Group, a sub-group of the steering committee. There are distinct characteristics identified within the consumers’ geographical location and community size, as consumers are more likely to know each other or be related and personally know the practice nurse delivering the healthcare in smaller communities. In an explorative study investigating the expectations of rural GP clients, it was found that clients over 55 years of age expect to see the same doctor, young and middle aged men seek acute and emergency care at their local surgery and that bulk billing is not an
important factor in accessing medical services (Humphrey et al. 1997). However, the findings of Humphrey et al. (1997) have since been contradicted by Cheek et al. (2002), who found the cost of rural GP services is important to consumers, and consumers expect the practice nurse to triage and provide emergency care. The study by Cheek et al. (2002) exploring consumer expectations of nursing and nurses in general practice in Australia significantly identifies that consumers expect practice nurses have appropriate skills and knowledge to provide information and follow-up care under the direction of the doctor and do not expect the nurse to substitute care from the general practitioner.

Collaboration in general practice

Collaborative practice, where the care is shared between GPs and nurses, has been found to be essential to the delivery of quality care in the general practice setting (Mills 2008; Willis et al. 2000; Patterson & McMurray 2002; Harris et al. 2007; Proudfoot et al. 2007). ‘Shared care’ has been defined as:

an approach to care which uses the skills and knowledge of a range of health professionals who share responsibility in relation to an individual’s care, including, monitoring and exchanging patient data and sharing skills and knowledge between disciplines. (Morehead 1985 cited in Willis et al. 2000, p. 239)

In a consensus development conference, using a panel of experts in a formal method of consensus development, Halcomb, Davidson, Yallop, Griffiths & Daly (2007) discussed strategies to improve the management of cardiovascular disease within general practice with shared care. These experts identified a need for cultural change through greater collaboration and team building rather than defining the differences between individual professional roles of the GP and practice nurse. Characteristics of teamwork were explored in an action research study on nurse cervical screening with three registered nurses working in general practice credentialed to provide cervical screening services. The study involved six reflective group meetings held by the researchers over a six month timeframe (Mills & Fitzgerald 2008). Important team characteristics identified are: open communication, access to referral pathways, opportunities to develop nurse champion leaders with nurse-led clinics, recognition of knowledge and skills utilised in collaboration with GP services, flexibility of working hours and opportunities for continuing professional development.
The importance of teamwork between GPs and practice nurses has been studied by Patterson, Muenchberger & Kendall (2007). The researchers used a focus group format involving seven practice nurses, six general practices and 25 GPs. The focus group reviewed the extent of practice nurse satisfaction in relation to the sustainability of the practice nurse role in coordinated collaborative care by exploring communication processes and long term viability of team care management in a trial of chronic disease patient care planning processes. The authors identified there is an unstructured approach to coordinated care in the implementation of chronic disease assessment and care plans in general practice. Despite previous experience in care planning in the community and domiciliary setting, practice nurses found it is difficult to balance usual demands with additional demands of the trial care planning. One nurse cited, “there are some doctors who will use nurses just to clean their equipment…we need fulfilment and professionalism” (Patterson et al. 2007, p. 233). In hospitals, a professional collaborative interaction is established for both nurses and doctors, however sharing care and teamwork is less defined in the general practice setting between practice nurses and GPs (Nowark & Bickey, 2005).

**Practice nurse autonomy and Medicare**

The literature identifies that with the current funding arrangements from Medicare, autonomous nursing care roles are restrictive (Halcomb et al. 2006; NSW Health 2005; Nowark & Bickey 2005). Nearly every nurse-client interaction (other than wound care and immunisation) is required either to be intercepted or supervised by the general practitioner in order for the business to be eligible to claim Medicare funding for services rendered (Willis et al. 2000). Under this structure, Willis et al. (2000) observe that nurses are “presumed responsible, but not autonomous or partners in shared care”. The current Medicare structure in general practice is found to encourage high patient flow, that is, high volume with short consultations (NSW Health 2005). This impacts on the quality of nursing care, particularly where longer consultations for clients with complex chronic care is needed (Phillips et al. 2007). There are no Medicare rebates to GPs that reflect quality of nursing care and time. The balance between these conflicting values of “quality of care” and the “cost of care” is not new to nurses, as seen with the controversy in casemix funding in the hospital setting where funding is allocated according to the patient’s diagnosis (Nowark & Bickley 2005).
Reduced job satisfaction is also related to time limitations in scheduling nurse-client care, due to increased surveillance of eligible patients for Medicare rebates in general practice (McDonald et al. 2007; Phillips et al. 2007). Enhanced primary care (EPC), chronic condition care planning related items, have increased practice nurse duties with pressure to remind and encourage clients to be compliant with regular review visits to increase Medicare rebates for the GP’s business (McDonald et al. 2007). In a qualitative field data collection within a mixture of remote, rural and urban general practices, Phillips, Dwan, Pearce, Hall, Porritt, Yates & Sibbald (2007) identify that “good care is seen to merge through the unstructured interaction of the patient and nurse”. These authors identify that, when nursing time is made “flexible”, patients may elect to see the nurse rather than the doctor so as not to “waste” doctor time (Phillips et al. 2007). The importance of having time for a “chat” with clients enables the practice nurse to elicit valuable information which may be clinically significant and relevant to the current presentation or health assessment, or prove invaluable for later referral. Phillips et al. (2007, p. 133) identify that practice nurses describe this “chat” time as an “enjoyable” aspect of their work.

Key Theme Three: Practice nurse competency

This third theme, practice nurse competency, links in with the previous theme about practice nurse role expectations in general practice. This section contains three sub-themes: practice nurse education and training, determining practice nurse competency, and professional boundaries: medico-legal ambiguity in practice. This theme will present literature that identifies a mismatch in education and training and competency expectations for the task between the GP and the practice nurse, and the professional implications of the mismatched nurse role preparedness and expectations.

Practice nurse competency standards are described in Nursing in General Practice Recruitment and Orientation Resource, which was published by the AGPN in 2006 and aims to clarify the practice nurse role, and professional development for practice nurses who move from other clinical nursing settings into general practice. The resource provides an overview of professional issues such as registration and competency standards for nurses in general
practice, as well as information on professional indemnity considerations in relation to the scope of practice for nurses (AGPN 2006). The RCNA (2005) defines scope of practice as:

*The scope of practice for each nurse is based on the individual’s education, knowledge, competency and extent of experience and lawful authority... A part of a nurse’s legal responsibility is that they do not practice outside their scope of practice.*

(RCNA 2005, p. 15)

Practice nurse training and education emerges as a need for practice nurse preparedness for the nurses’ scope of practice throughout the literature.

**Practice nurse education and training**

Education and training is found to increase feelings of self-worth and respect, as well as recognition by peers in the hospital setting, which can be highly satisfying to nurses (Chan et al. 2004). Barriers to ongoing rural practice nurse education to support practice nurses in their role has emerged from the literature. Post basic registered nurse training is found to be limited in rural Australian nursing (Gibb et al. 2005; Hegney et al. 2002a). *Rural* nurses spend most of their working life in the same setting and are likely to remain until they retire (Hegney et al. 2002a). The authors found that rural and remote nurses who had resigned in Queensland were predominantly unaware that lack of continuing education compromised their own professional development and could negatively affect the quality of healthcare delivered (Hegney et al. 2002a). In the UK, compulsory practice nurse education is stipulated by the NHS, with some components funded by the NHS and other components funded by the practice nurse themselves or their employer (NHS 2009). However, the notion of encouraging practice nurses to improve their education to become autonomous in their role is not always supported by GPs. Nursing contribution to general practice was studied by Patterson et al. (1999). Using separate focus groups of both GPs and practice nurses found support for the autonomous functioning of the practice nurse was divided; 71% of GPs reiterated their view that practice nurses should be employed to do only directed tasks, and 40% of GPs believe that an expanded practice nurse role would lead to “second-rate medicine”. In contrast, 77% of practice nurses envisage their role would encompass other non task-orientated roles (Patterson et al. 1999). The research data at the time suggests there is a mismatch in the expectation of the nurses’ role and education, between the GP and nurse.
Despite inconsistencies in the role and education of practice nurses, there is optimism for role expansion. Following a literature review on the evolution of general practice nursing in Australia, Halcomb et al. (2006) describes how practice nurses need to take their own initiative and make independent decisions based on their experience and education, rather than relying on medical delegation to extend their role (Halcomb et al. 2006, p. 378).

Education opportunity has been researched by Meadley, Conway & McMillan (2004) using a four phase, mixed method, descriptive study entailing: a telephone audit of 180 practice nurses, a literature review, survey and follow-up of one focus group of GPs and practice nurses in an Australian urban Division of General Practice with a population of 400,000 people. The reasons for lack of education opportunity were cited in two categories, professional and personal. Professional reasons cited were: cost to practice, GP not up-skilled saw little need for practice nurse education, and education and training opportunities were perceived irrelevant by practice nurses. Personal barriers identified by Meadley et al. (2004) included: time, work commitments, family commitments and financial problems meeting the costs of such courses.

The education needs of nurses working in general practice was explored by Pascoe, Hutchinson, Foley, Watts, Whitecross & Snowden (2006). Similar to findings from Meadley et al. (2004), practice nurse education is found to be important to most practice nurses. Pascoe et al. (2006) indicated that education is important to 90% of the 222 practice nurses surveyed, with 94.6% of nurses having gained non-formal education in the last two years, of which 51.4% of these nurses sourced education through informal education sessions and seminars (Pascoe et al. 2006). This survey identified that rural practice nurses (20.5%) cite distance to training as a “pertinent barrier” to further education, compared to 3.6% of urban practice nurses (Pascoe et al. 2006). Focus groups in this study identify that increased support for practice education should include: tailored programs to the general practice environment, advanced competency choices to promote career choice, clinical and theoretical education for practice nurses, assessment and accreditation of the education delivered against national education standards (Pascoe et al. 2006).

In 2007, Australian practice nurse education was predominantly delivered from Divisions of General Practice who provided education and support for practice systems that involve GPs.
as much as practice nurses (Hall 2007). Australian nurse affiliated organisations such as APNA and the RCNA also provide practice nurse professional development; however, the cost was burdened privately or won through scholarship programs (McDonald 2008, p. S70). Within England, where practice nurses are employed in both the private and public sector, the primary healthcare nurse model covers a variety of primary healthcare services from nurse practitioner to generalist nurse in general practice (McDonald et al. 2008). Unlike in the Australian setting where practice nurse continuing professional development is the responsibility of the nurse and can be negotiated with their employer, in England the practice nurses employer (Primary Care Trust) must provide for mandatory training sessions: fire safety, basic life support, child protection awareness, anaphylaxis training and infection control (NHS 2009). At the time of this literature review, the New South Wales Nurses and Midwives Board did not have stipulated minimum educational requirements for currency of nurse practise.

**Determining practice nurse competency**

Clinical competence was investigated by Halcomb et al. (2008) with postal surveys conducted between 2003-2004 with 284 practice nurses, with 44% of participants working in a rural or remote area. Most participants (92%) felt they were competent with core nursing skills, and a mean of 9% identified that they needed further education or training in these skills. Advanced practice skills, including health assessment and advanced physical examination, were undertaken by 22% of the participants (Halcomb et al. 2008). An advanced nursing practice model was described by the ANF as “a level of practice between beginning and expert levels in either a specialist or a generalist context” (ANF 2005, p. 5).

The findings from this survey identify a significant relationship between advanced practice nurses as they either work more than 25 hours per week, or worked additional hours nursing outside general practice (Halcomb et al. 2008).

In terms of health promotion and prevention activities, only 63% of nurses found it was appropriate for their general practice role (Halcomb et al. 2008). This is problematic, as health promotion and prevention activities are expected of practice nurses in the NiGP Initiative (DoHA 2002). A professional standards framework that can be used to measure practice nurse competency was formulated by the ANF and AGPN (AGPN 2006) that provided a self-assessment tool for a nurse to assess his or her own performance, knowledge
and skills. The relationship between clinical skill competency, practitioner and the demographical location could not be demonstrated by Halcomb et al. (2008). Since this data were collected in 2003, there has been a significant improvement to practice nurse education opportunity especially with the availability of postgraduate and continuing education development scholarships and online learning opportunities (APNA 2008); however an evaluation of the effectiveness of educational opportunities in relation to practice nurse competency is yet to be identified in the literature.

Professional boundaries: Medico-legal ambiguity in practice

Registered nurses are employed as professionals and have been found to assume work within a required level of autonomy in practice, including their ‘professional level of judgement’, accountability, and trust (Nowak & Bickley 2005, p. 410). Caldwell (APNA 2007, p. 41) identifies that nurses “are obliged to work within the scope of practice and they are accountable and responsible for this”; however, GPs need to understand the term ‘scope of practice’ and judge if the nurse is capable and how best to enhance their skills into the future (Caldwell 2007, p. 41). However, there is no literature that evidences GP education to prepare them for working with a practice nurse.

Ambiguity in general practice has been linked to Medicare PIP payments and fee structure as there are financial incentives to general practices for the employment of practice nurses who may be employed for roles where they are neither necessarily qualified nor competent (Murray & Wronski 2006). The authors show concern that ambiguity about where this responsibility lies and will potentially leave the practice nurse vulnerable to medico-legal implications, especially where their practice falls outside the letter of the law in terms of patient education in chronic disease (Murray & Wronski 2006). If a patient is harmed by a nurse employee working in general practice as a result of the GP’s negligence, the GP has the legal responsibility based on vicarious liability (AGPN 2006). The negligence of the nurse needs to be proven to have occurred in the scope and course of the employment relationship (AGPN 2006). However, the employer, or very rarely the patient, may decide to sue the nurse or the nurse as well as the employer (AGPN 2006, p. 69). The APNA website encourages practice nurses to consider insuring for sufficient medico-legal professional indemnity insurance.
Key Theme Four: Practice nurse support

The fourth and final theme of this literature review provides insight into the support mechanisms in place for practice nurses. The practice support mechanisms in the literature have been grouped into three sub-themes: remuneration, financial support and healthcare policy. Remuneration concerns for practice nurses relate to dissatisfaction as they are paid less than hospital colleagues, with leave relief proving problematic. The literature describes current financial support strategies via Australian Government initiatives for rural GP workforce retention that aim to attract and maintain rural GP workforce numbers, however, there are no strategies identified for practice nurses, other than Australian Government Scholarship support for practice nurse education, and the practice nurse professional support organisation, the APNA.

Remuneration
A recurring problem for practice nurse retention is low practice nurse remuneration which reduce job satisfaction as indicated in APNA Salary and Condition Surveys conducted in 2007 and 2008 (APNA 2007; APNA 2008; Halcomb et al. 2007). The national online surveys conducted by APNA (2007; 2008) find the majority of practice nurses are paid considerably less than their colleagues in the public sector (Annells 2007). Each practice nurse is encouraged to individually negotiate remuneration issues (APNA 2008; Halcomb et al. 2007). Member pay and conditions have been surveyed annually by APNA since 2004. APNA have been actively canvassing the Government for the implementation of a practice nurse award (APNA 2008).

Leave relief for practice nurses has been identified as problematic when practice nurses seek holiday and sick leave relief, particularly for solo practice nurses who often take on a large workload (Hall 2007). Hall (2007) identifies it is difficult for the practice nurses to defer this workload to the GP when taking leave as locum support services only exist to cover leave of absence for rural general practitioners (Hall 2007).
Financial support
To entice GPs from urban areas to the needy rural areas substantial financial incentives are provided (National Rural Health Alliance (NRHA) 2002), however, these government incentives do not extend to rural practice nurses despite rural workforce shortcomings. Key recommendations are proposed in Action on Nursing in Rural and Remote Areas 2002-03 to attract and retain both rural and remote nurses (NRHA 2002). Suggested incentives for rural nurses include: housing and relocation support, reimbursement for travel costs to see family at least annually and the provision of leave to compensate this isolation, study allowances including leave and financial support, salary loading to reflect the degree of isolation and “education on local cultural issues” (NRHA 2002, p31). To date, rural practice nurses have received financial support for practice nurse education scholarship (APNA, 2008). It is unclear if rural practice nurses would be attracted to rural general practice with the same extended financial support incentives as rural GPs, or some of the incentives suggested for rural nurses by NRHA (2002).

Healthcare policy
As practice nurses work for private business, there is a greater disparity in funding policy from secondary care institutions and community health facilities, particularly in urban areas (Hall 2007; Halcomb et al. 2006; Watts et al. 2004). In rural areas GPs employing a practice nurse receive a PIP subsidy as well as access to Medicare rebates for specific nurse services (Phillips et al. 2007). At the time of this literature review there is a review of the practice nurse funding mechanisms across Australia. The review seeks to identify if a different funding mechanisms can expand the scope of the practice nurse role where practice nurse autonomy is not restricted by current funding from Medicare.

New educational opportunities have emerged since 2005 as APNA has provided scholarship opportunities and online learning modules to practice nurses (APNA 2008). APNA has awarded over 1,691 continuing education and postgraduate scholarships to practice nurses, totalling over $1.8 million of educational assistance from 2005 to 2008 (APNA 2008). It is unclear if the greater number of practice nurse specific courses, through tertiary institutions such as The College of Nursing and the many universities, will provide adequate educational support to rural practice nurses. Access to education, particularly for the solo practice nurse, has been identified as important by Halcomb et al. (2005), due to the risk of professional
isolation. Follow-up research is needed to identify the impact of such incentives on rural practice nurses, and their willingness to participate and contribute to their personal and professional development.

APNA is self-funded and seeks to develop professional recognition, a professional structure and empowerment for practice nurses (APNA 2008). Membership to professional nursing organisations such as APNA and the RCNA is strongly supported by 62.7% of practice nurses surveyed by the AGPN in 2007. The progress of these organisations will be pivotal in the successful implementation of a professionally recognised career structure for practice nurses which will attract and retain rural practice nurses (Halcomb et al. 2005). The recognition of practice nursing as a career opportunity with a clear pathway needs to be explored in relation to its impact on the satisfaction and retention of rural practice nurses.

Conclusion

As there are no research studies solely on rural Australian practice nurses it is not possible to accurately identify issues affecting practice nurses working in a rural area where there are health workforce shortages and health disadvantaged populations. The social and professional issues have implications for the future recruitment and retention of the rural health workforce, particularly due to the unique challenges associated with the rural health workforce shortage. Since the introduction of the NiGP Initiative in 2002 the practice nurse role has been evolving and is expected to provide support to GPs, particularly for general practice clients with chronic and complex disease states.

The literature review has found four themes related to the recruitment and retention of rural practice nurses. An exploration of nursing in the rural context relates to the primary healthcare needs of rural populations with low accessibility to healthcare, followed by literature relating to the rural health workforce in terms of recruitment and retention studies of rural health professionals including nurses, doctors and pharmacists. Attractions are the rural lifestyle, family work obligations, knowing the community and employment opportunities. However some of the reasons rural health professionals have left rural practice are that they became dissatisfied with loss of anonymity, lack of education and training, and
lack of career progression. The section on integration of nursing into general practice in Australia describes the evolution of practice nursing into general practice and the integration of the nurses from other settings into a restricted collaborative role with a GP. A discussion on practice competency identifies the lack of adequate preparedness of practice nurses for their role, which is a constantly evolving role that requires challenging education and training to maintain competency in line with Medicare rebates for health prevention and promotion initiatives. Practice nurse support described the problems associated with low practice nurse remuneration, low financial support for practice nurse education and restricting healthcare policy implications and general practice business funding mechanisms of the practice nurse role.

Within this literature review, the methodologies used by other researchers have been reviewed to identify the methods used to extract data in qualitative and quantitative studies. This information has provided the researcher with background knowledge to support the best possible method of research design, data collection and data analysis for an exploratory research project. As explained in this literature review, mailout surveys have predominantly been used to identify qualitative and quantitative data across large areas of Queensland. The interviews used by Hays et al. (1997) and Harding et al. (2006) were exploratory qualitative studies as there has been little known about the rural GP workforce and the rural pharmacist workforce (respectively). Semi-structured interviews have proven to be effective as they elicit strong and meaningful responses by using both open and closed questions to extract data related to the recruitment and retention of smaller groups of doctors and pharmacists, respectively. Specifically the response depth enables the qualitative data to identify strategies for improvement in support programs for rural doctors (Hays et al. 1997) and pharmacists (Harding et al. 2006).

The future: implications for practice, education and research

Now that practice nurses have been recruited with support from Australian Government programs (DoHA 2006), the practice nurse workforce is one that is ageing (APNA 2008), and this compounds the implications for workforce retention. This literature review found scant
current research on the *rural* practice nurse role and the implications of social and professional issues that may effect the sustainability of this workforce. The *rural* general practice setting is unique and unfamiliar to most researchers when compared to research on general hospital and community nurses.

The literature identifies rural areas as having health workforce shortages, especially general practitioners, and the 2002 NiGP Initiative was introduced to support the rural and remote general practice workforce. Whilst there is little known about the *rural* practice nurse in the literature, the need to support practice nurses with skills, knowledge, infrastructure, a career structure and remuneration is found to be key in attaining and maintaining practice nurse satisfaction. An Australian explorative study on the role of the rural practice nurse would not only be the first Australian study on rural practice nurses, it would also be a significant starting point to provide insight on strategies to retain practice nurses in order to sustainably support the high health needs of rural communities and the general practitioner workforce.

**The Research Study**

Following this literature review, it has been determined there is a significant knowledge gap about what is known about the *rural* practice nurse role and the social and professional issues that effect this valuable workforce. The research question aims to explore the issues that effect rural practice nurse retention is, *What are the social and professional issues that effect rural practice nurse retention?* The three aims of the research are firstly to investigate reasons why rural practice nurses continue in the Australian workforce, secondly to identify social aspects that effect rural practice nurse retention, and thirdly to identify professional aspects that effect rural practice nurse retention. The next chapter describes the qualitative research methodology and methods used to explore the aim and objectives of this significant first Australian *rural* practice nurse investigative study to find ways to sustain this workforce.
3. Method

Introduction

This chapter will present the methodology used in this study. The research question is, *What are the social and professional issues that effect rural practice nurse retention?* The three aims of the research are to investigate reasons why rural practice nurses remain in their role in primary healthcare, identify social aspects that effect rural practice nurse retention and identify professional aspects that effect rural practice nurse retention.

There are three main sections in this chapter. The first section presents the rationale for choosing a qualitative research design, incorporating the underpinning philosophy of why a qualitative process has been chosen. The second section describes the data collection including participant recruitment, development of the interview tool and transcription of the voice recordings. The third section describes and provides rationales of the data analysis, incorporating the computer software analysis support, determining data saturation, data interpretation with thematic analysis and the credibility, dependability and transferability, and overview of the ethical considerations associated with this study.

Qualitative research design

The chosen study design required an investigative qualitative approach to provide an understanding of the unknown role of rural practice nurses with an exploratory analysis of data. The literature review explored studies on the recruitment and retention of rural health workforce and practice nurses which all used a qualitative data to explore the unknown roles and job satisfaction. To investigate the social and professional issues that may impact on the recruitment and retention of rural practice nurses, semi-structured interviews with rural practice nurses identified a starting point from which to understand the lived experiences of nurses in rural Australia. The researcher sought an understanding the rural practice nurse role and a purposive and convenience sample of rural practice nurses was selected. A thematic
analysis of data were used to explore the social and professional issues that may effect the job satisfaction of practice nurses, thus affecting their intention to stay in or leave practice nursing.

Associated with a qualitative research design can be a set of ‘adjectives’ that seem to fit with qualitative data and this mode of analysis (O’Leary 2005, p. 99). Adapting the assumptions and protocols described by O’Leary (2005, p. 99) to this study provides a rationale for a narrowed and predetermined methodological path. In this study the methodological path evolved from the beginning where a qualitative approach was chosen to provide an exploratory approach underpinned by phenomenology. The exploratory approach of qualitative research provided a method that allowed the researcher to identify concepts that are explored and interpreted to gain an understanding of the rural practice nurse role and identify issues that may affect job satisfaction and the retention of the workforce. Phenomenology was integrated in the methodology to gain a better understanding of the lived experiences of this population (O’Leary 2005, pp. 121-122). The 18th and 19th centuries saw the beginning of phenomenological concepts in writings by Husserl (Smith 2008). Phenomenology is literally the ‘study of phenomena’ which can be studied in various forms, such as, social, philosophical, hermeneutical, psychological and transcendental. The phenomenological underpinnings for this study were social, as the researcher needed to explore human phenomena and how as individuals they “go about making sense of their direct world” (O’Leary 2005, p122).

“The philosophical underpinnings of phenomenological thought are Consistent with the values of nursing practice- the uniqueness of the person, the importance of personal discovery and acceptance of life situations, the need for the exploration of meaning of experience, interpersonal relationships, potential for personal growth, and use of self as a therapeutic tool” (Edward 2006, p.238).

Heidegger (who was a student of Husserl), as cited in Lavety (2003) viewed the human experience as it is lived, and this ‘living’ involves acts of perceiving, recalling and thinking about the world and also includes aspects of culture, society and history (Laverty 2003, p.6). Heidegger describes this view as meaning or ‘being’ (Converse 2012, p.30). The use of phenomenology as a research methodology by nurse researchers began in the 1970s and has become dominant basis for nurse research (Earle 2010). A critical review of the use of
phenomenology in nursing was undertaken by de Witt & Ploeg (2006) who concluded that this was a valid and reliable form of qualitative research mentor as long as it had rigour specific to the research. A phenomenological interpretation of dying in cancer critical illness, and the impact on opportunities for end-of-life care, was conducted by Pattinson, et al. (2013). The authors used data from taped interviews with patients in critical care setting, and found that healthcare professionals can help facilitate acceptance for families and patients, particularly in patient advocacy and decision making (Pattinson et al. 2013). In the Primary Health Care setting, Holmström, & Dall'Alba (2002), conducted a study to describe how nurses experience the patient encounter when performing telephone advisory services. The interview data transcripts were interpreted with a phenomenological data analysis method and found that the nurses’ roles were characterized with conflicting demands of being both carer and gatekeeper (Holmström & Dall'Alba 2002).

The phenomenological underpinning was highly reliant on the participants’ responses to the interview questions, where they could share their experiences of rural practice nursing and provide insight into their lived experiences. Data from the responses of all nurses were collated, similarities in responses grouped, and the essential nature of the responses interpreted with both reflective and analysis cycles, from which eventuated themes.

Figure 3.1 displays the rationale linking the qualitative methodologies. This figure has been adapted from O’Leary (2005, p. 99, Figure 7.6). This figure (Figure 3.1), demonstrates how the measurement of qualitative research is developed from assumptions that are deduced from exploratory, interpretative and constructive enquiry. Adapting the underpinnings of phenomenological enquiry, a “value laden, biased, ad hoc process that accepts multiple realities”, enabled the researcher to deduce the interview responses of a relatively small number of participants (O’Leary 2005, p. 99). This figure (Figure 3.1) then demonstrates how these beliefs were adapted into “assumptions and protocols” that formulated the predetermined methodological approach to qualitative data method (O’Leary 2005, p. 99). In this study analysis was achieved using an explorative thematic analysis adapted from grounded theory.
A semi-structured interview tool was used to provide data from the nurses' own lived experiences on what affects them and how they go about their roles. This provided the researcher insight into their lived world (Patton, 2002). The selection of participants for individual semi-structured interviews was both purposive and convenient to the researcher due to the geographical location of the study. A purposive sample has been collected as all the practice nurses working within one rural Division of General Practice were identified by the Division. The target population was identified from a database of rural practice nurses working within a rural New South Wales Division of General Practice (RRMA 4). The participants were selected based on convenience of both the researcher and participant’s time. This meant there would be few problems associated with the need for the nurses to travel distances from the villages where they work, and having the researcher conduct an interview close to where the nurses work and at a time suitable to their working hours and commitments was convenient to the participants.

Following the semi-structured interviews, data were transcribed for qualitative analysis. Using the elements of thematic analysis, the conceptualisation and categorisation of the interview data has resulted (Braun & Clarke 2006). Thematic analysis, derived from a grounded theory analysis formulated by Strauss (1988, p. 11), enabled the researcher to create categories in relation to the data. ‘Open coding’ is a term used by Strauss (1988, pp. 29) where ‘codes’ are applied to data, then the data were sorted into patterns, creating a category.
The data were labelled with a description of each category, then grouped into sub-themes and then into themes (Strauss 1988, pp. 34-36), and related to rural practice nurse satisfaction and retention. Whilst this qualitative study utilised some aspects of grounded theory, the data analysis methods were not solely from grounded theory. The steps used in the thematic analysis of the data are discussed in more detail later in this chapter.

Data collection

This describes participant data collection using the semi-structured interview tool and the transcription of the voice recordings.

Participant recruitment

The target population all worked as registered or enrolled general practice nurses in a rural New South Wales Division of General Practice. The sample chosen for this research is purposive: rural practice nurses. The location used for the research has a RRMA classification of 4 (PHCRIS 2009, np). The nurses recruited work in five different villages, within the town centre. Most of these villages are 30 to 40 minutes from the major town centre.

There were 61 practice nurses (58 registered and three enrolled nurses) in the selected rural area invited to participate. Potential participants were approached via a third party, a Practice Nurse Support Coordinator at the Division of General Practice. Confidentiality was ensured as the third party distributed participant information sheets and consent forms to all eligible practice nurses known to the Division of General Practice in the research area. Practice nurses who were willing to participate completed the consent form and returned them to the nominated third party, who then gave the responses to the researcher. The consent form contained written contact information provided by the participant. (The Participant Information Sheet and the Consent Form can be viewed in Appendices 1 and 2, on pages 135-8)
There were 22 responses from the 61 invitations distributed. The participant availability was noted on the returned consent form. Participants were selected for interview based on their elected availability and the mutual availability of the researcher. Upon determining individual availability for interview, participants were allocated days of the week then selected from groups with the same availability and a time was arranged for interview. The interviews were conducted between 13 November 2008 and 6 March 2009. A total of seven practice nurses were interviewed in this study before data saturation was determined. Nurses who had consented to interview but were not required were phoned and advised that no further interviews were being conducted as the interview data collection was complete, and thanked for their willingness to participate.

**Development of the tool**

Interviewing enabled the researcher to investigate the aims of the research, that is, to understand what attracts nurses to rural practice nursing, if expectations of rural practice nursing are met, and intention to leave practice nursing. The uses of both open and closed questions are used in semi-structured interviewing. Closed questions “force respondents to choose” their responses that have a predetermined range from the researcher (O’Leary 2005, p. 159). The semi-structured interview tool was selected as this was thought to be a flexible tool that suited the research question, as depth could be ascertained in the participant responses through the use of prompt questions. Closed interview questions provided responses that allowed the researcher to collect demographical data. The Interview questions can be viewed in Appendix 4 on pages 140-1.

Open interview questions allowed the respondents to “construct answers” using their own descriptive words (O’Leary 2005, p. 159). This method allows respondents to formulate their own opinion or express information about the topic to generate rich data for coding and analysis (O’Leary 2005). Responses from the open interview questions were used to advance understanding of how rural nurses are currently satisfied in their role in two ways: firstly social issues within the rural setting and secondly, professional issues within the general practice setting.
The interview tool developed for this project was adapted from a combination of open questions used to explore the recruitment and retention of rural health professionals in the literature: Harding et al. (2006) investigated rural pharmacists, Hegney et al. (2002b) investigated rural nurses, and Hays et al. (1997) investigated rural GPs. Prompt questions were used to trigger and probe the attitudes, beliefs and opinions of the nurses in a conversational flow and to investigate interesting tangents as they developed (O’Leary 2005). Closed questions that elicited demographic practice nurse data were adapted from workforce survey questions used by the AGPN (2007). The interview tool was checked for content and process reliability with a practice nurse – there were no changes to the interview questions deemed necessary.

The semi-structured interview process was framed by six main questions. As an overview, the six main questions covered demographic data; social and professional reasons that attract nurses to general practice; rural context and professional issues that impact on the nurses’ preparedness or not for the practice nurse role; social and professional implications of practice nurse education in terms of preparedness, needs and opportunity; social and professional relationships from living and working within a rural community; and the nurses’ future considerations, that is, if they intend to stay or leave and if their expectations of the practice nurse role had been met.

**Justification for questions**

This survey was developed to collect data to explore the objectives in two ways. Firstly, a one question analysis to compare the responses in the same question against each other. Then the responses were compared to determine if the variables are dependant or independent of each other. The demographic data of the nurse – age, sex, years since graduation, length of time practice nursing – can be used to deduce if there is any relationship between the years of experience and responses relating to job satisfaction.

The three research project objectives were explored with the following questions:

**Objective One: Role preparedness**

- Tell me, how many years have you been nursing?
- How long have you been practice nursing?
What post-basic education have you had that you use in your practice nurse role?
Please tell me what attracted you to practice nursing?
In your opinion, does rural practice nursing differ from that of an urban practice nurse?
Do you feel you were adequately prepared for the role? If so, how? If not, why not?
Do you feel you have clear professional boundaries? Is your role clearly defined?
Do you intend to leave practice nursing? If so, when? for what reasons?

Objective Two: Practice Nurse Education
Tell me, how many years have you been nursing?
How long have you been practice nursing?
What post-basic education have you had that you use in your practice nurse role?
Explain what formal education you have had to prepare or support you in the practice nurse role? In retrospect, do feel this was adequate?
Is rural practice nurse education adequate for your professional development? How is clinical supervision provided? Do you feel you are adequately supported by professional bodies? If so which ones?
Do you intend to leave practice nursing? If so, when?, for what reasons?

Objective Three: The rural context and general practice setting
Tell me, what do you think of living and working in your community? What do you like? What don’t you like? Give me some examples?
Please tell me what attracted you to practice nursing?
In your opinion, does rural practice nursing differ from that of an urban practice nurse?
Explain what formal education you have had to prepare or support you in the practice nurse role? In retrospect, do feel this was adequate?
Do you intend to leave practice nursing? If so, when?, for what reasons?

Question structure
Open-ended questions have been utilised for the following reasons:
1. The researcher has limited prior knowledge about the topic as there is little evidence-based research specific to Australian rural practice nurse retention, so response
choices cannot be specified. It also allowed the researcher to explore unknown subjects that emerge from responses.

2. This format provides the participants an opportunity to disclose strong opinions, vent frustrations, or discreetly let the researcher know if anything may have been overlooked.

3. Useful when the practice nurse needed to describe a routine behaviour for which there were no exact numbers.

4. To elicit precise pieces of demographical information is needed, including their age, years since graduation, qualifications and ongoing training, and how long they have lived in a rural community.

**Interviews**

Interviews were conducted until no new themes emerged. The interviews took place away from the participant’s usual workplace to reduce interruptions, noise and inhibition. This added to the quality of the recordings for transcription and permitted unimpeded discourse from the practice nurse.

**Transcription of voice recordings**

Once each interview had been completed, the de-identified voice recording was loaded from the recorder to a Windows computer audio file on CD and was sent for professional verbatim transcription. The researcher was supported by the services of a trained and experienced transcriber to ensure objectivity and accuracy from the digital voice recordings in transcription. There were three transcription codes used by the transcriber. Firstly, where there was difficulty with exact interpretation of the word from the sound, ‘sounds like’ was put in brackets ‘( )’. Secondly, where the interview was interrupted, or word articulation was not understood from the participant or researcher either because they were laughing or spoke quickly, ‘xxx’ was displayed. Thirdly, where names of people were identified, this was identified with an ‘**’ symbol in the transcript.

Following the return of each transcription, the researcher rechecked the documents against the voice recording for accuracy, and where needed, details within the text were altered to accurately record what was stated by the participant. Then to improve validity, the transcriptions were offered to the participant to review for accuracy. Having two people (the
participant and researcher) checking for verbatim transcription ensured that all words were heard and recorded accurately (Perakyla 2004).

Data analysis

Within this section on data analysis there is a discussion on computer software analysis support, determining data saturation, data interpretation using thematic analysis, the credibility, dependability, and transferability of this study.

Computer software analysis support
To facilitate the process of data analysis, computerised NVivo 7 software was used throughout. NVivo assisted the researcher in the data analysis process by facilitating efficiency and effectiveness of learning from the data (Bazeley 2008, p. 2). With the aid of specialist NVivo research assistance, the technical capacity for recording, sorting, matching and linking the data were used to assist in answering the research questions. This ensured there was no loss of connection between the source and the context from which the data had come (Bazeley 2008, p. 2). Kelle (2004, p. 485) noted with computer analysis it is important that coding is inclusive and exhaustive which ensures every category is adequately coded.

Determining data saturation
Review of the data with research supervisors suggested that after seven interviews had been conducted there was no benefit to continue, as there were similarities and repetition in responses. Due to the exploratory level of the enquiry it was determined the seven interviews had provided sufficient data for meaningful and useful analysis as there were no new themes emerging (Morse 2000). Guest, Bunce & Johnson (2006) and Morse (2000) suggest data saturation occurs when the same sorts of themes are identified and no new themes have emerged. Upon rearranging the categories it was evident that many sub-themes and themes began to overlap, which was not apparent in the early stages of the analysis. After the fifth interview, the importance of some initial categories dwindled in the analysis as they were not found to be linked to nurse satisfaction. After five interviews, the possibility of data saturation was discussed with supervisors, and it was agreed a further two interviews would be sufficient to clearly identify if data saturation had been achieved. Following analysis of
further two interviews, categories were reinforced, built upon and incorporated into existing sub-themes and themes from the first five interviews; however, no new concepts emerged. At this point, the sample size and category development were attained as “no new properties, dimensions, or relationships emerge(d) during analysis” (Strauss & Corbin 1998, p. 143). Data saturation was determined after seven interviews as the same sorts of concepts and ideas were reoccurring and no new meaningful data could be interpreted in relation to the research aims.

**Thematic analysis**

This six stage process provided a framework based on research conducted by Braun and Clarke (2006, pp. 77-101) published in *Using thematic analysis in psychology*. The use of cognitive mapping portrayed the thematic development visually, as models assisted in the identification of relationships between categories, sub-themes and themes affecting practice nurse satisfaction. Thematic analysis is “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke 2006, p. 79). A theme “captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set” (Braun & Clarke 2006, p. 82). Braun & Clarke (2006, pp. 87-93) describe six stages of thematic analysis which provided a framework throughout the analysis process that evolved over a two year period. This research journey depicts an exploratory process underpinned by phenomenology, as the interpretation of practice nurse responses utilising this framework provided consistency and avoided misrepresenting important thoughts and feelings of the nurses.

These six phases of the thematic analysis have been schematically demonstrated in Figure 3.2. This diagram demonstrates the data analysis process from the initial phase of descriptive analysis – concepts and ideas formed from the words of the practice nurses – through to the thematic analysis – constructed from core categories – through to the final phases of critical analysis – where critical reflection of the findings and recommendations are constructed from the data.
Phase one involved becoming familiar with the data (Braun & Clarke 2006, pp. 89-88). This phase incorporated reading over and over the data transcriptions, listening to the voice recordings from the interviews, journaling ideas and memoing. Meetings with supervisors and a researcher familiar with NVivo software assisted the researcher to become immersed in the data, to improve the depth and breadth of content.

The second phase entailed generating the data into initial codes (Braun & Clarke 2006, pp. 88-89). The NVivo computer analysis tool, used for coding, provided a means of dividing the abstract data into descriptive categories and enabled a systematic grouping of likenesses and direct comparison of the nurses’ responses describing experiences, issues or attitudes (Bazeley 2008, p. 143). Each category description was scrupulously and systematically processed to achieve reliable data. Initially a descriptive analysis was sorted from the raw data of interview transcripts and journal notes. Strauss (1988, p. 29) refers to this initial analysis as ‘open coding’, the aim of which is to produce terms and concepts that can be clustered. Initially the concepts remained free and fully flexible, and were taken from individual words and lines from transcripts to keep the concepts open to interpretation. Concepts were identified from the in vivo (words) used, and the data were categorised with imagery construct followed by sociological construct (Bazeley 2008; Strauss 1988).
The third phase involved collating the data into potential sub-themes built from concepts to form a comprehensive picture that could relate to practice nurse satisfaction (Braun and Clarke 2006, pp. 88-89). The sub-themes acted as ‘signposts’ to support elements of the issues that affect practice nurse retention, and were pivotal for further interpretation and thematic considerations (Kelle 2004, p. 484). Strauss (1988, pp. 33-34) explains imagery construct where the in vivo language of the interviewee is very colourful, and the words used have very vivid imagery which allowed meaning to be interpreted. From there, the analysis was given depth by examining the broader social views against the meaning of what was said by the nurse in relation to other people or events. These words enabled the researcher to categorise concepts, adding a description to each category (Strauss 1988, p. 34). The description applied set parameters based on key words, thoughts and feelings of the participating nurses. Categories were collated and applied to broader themes. At this point, data were initially clustered under: family commitments, rural lifestyle, community belonging, professional roles, professional boundaries, relationship between doctor and nurse, relationship between nurse and client, educational opportunity, infrastructure, and the general practice business.

A series of cognitive thematic maps were formulated due to uncertainty that the themes could hold, or whether they needed to be combined, refined, separated or discarded (Braun and Clarke 2006, pp. 89-91). Cognitive maps provided a means of streamlining the massive process of data management throughout data analysis, particularly as qualitative research generates large volumes of transcripts and journal notes that needed to be analysed cohesively (Northcott 1996). Cognitive maps, or concept maps, are “graphic or pictorial arrangements of the key concepts that deal with a specific subject matter” (All and Havens 1997, p. 1210). These were formulated with models designed within the NVivo software. Throughout the data analysis, these models have provided transparency in both categorising the data and as a visual contextual display for ideas as a novice researcher progressed through the many stages of analysis, interpreting and remodelling the sub-themes and themes (Bazeley 2008).

The fourth phase, reviewing themes, required critical reflection of the categories within the sub-themes, then grouping into themes (Braun & Clarke 2006, pp. 91-92). The data from seven participants was broken down to 328 open coded individual concepts then allocated to
89 categories, divided into 13 sub-themes, before being collated into four themes: the pursuit of professional recognition, grooming nursing services to meet practice needs, being ‘good for business’ (making money), and mastering the art of living. At this point a series of cognitive maps were used to visualise connectivity in the relationships within themes and between themes. This process facilitated further refinement of the data within themes to ensure themes were meaningful in relation to practice nurse satisfaction. Descriptions within themes were reviewed to ensure clarity and clear distinction between themes. Some data required recoding to achieve an accurate reflection of the data as a whole (Braun & Clarke 2006, pp. 91-92).

Phase five, defining and naming themes, required further refinement of the data to produce a concise analysis that applied names to each theme with clear definitions to describe the journey the practice nurses had taken (Braun & Clarke 2006, pp. 92-93). In this phase the researcher reviewed the transcripts and original voice recordings to ensure data remained accurate. The tone of the nurses’ voices was important to identify and depict the emotional state of the nurses in relation to the theme content. Revisiting the raw data were important in this phase as it became very clear what had interested the nurse and why. This provided broader overview of their journey in rural practice nursing. This was related back to the research question and importantly, found to show little overlap between the four final themes (Braun & Clarke 2006, p. 92).

The sixth phase, producing the report, provided an opportunity to describe vivid and compelling extract examples of the practice nurses’ journeys (Braun & Clarke 2006, p. 93). The selective verbatim quotations from the practice nurses provided in the results and discussion chapter were incorporated, as they provided clear images embedded within a critical analysis. Finally, the outcomes of this analysis were related in a concise manner to the study question on rural practice nurse retention, and the recommendations for future consideration arising from the study.

**Credibility, dependability and transferability of the research study**

The credibility in quantitative research depends on instrument construction, in qualitative research, “the researcher is the instrument” (Patton 2001, p. 14). The interview tool was checked for content and process by another practice nurse ensured the interview tool was
valid prior to the study. The semi-structured questions were found to provide open and closed questions that were clear, logical, relevant, unambiguous and valid. Additionally, the interviews were professionally transcribed and the transcripts checked by the researcher and, in three instances, participants agreed to check the accuracy of their verbatim interview transcript. The transcriptions were validated as accurate by the participants and no changes were made. This process ensured consistency in the datum obtained for each interview.

The dependability of qualitative research is likened to reliability in quantitative research (Goldafshani 2003, p. 602). The consistency of data in this project has been achieved through verification by research supervisors and the use of NVivo 7 software, whereby an examination and discussion of raw data coding into categories, then data reduction and grouping of relevant data into sub-themes and themes with a systematic and critical analysis within a thematic analysis occurred. This incorporated the review of journal and memo notes from semi-structured interviews (Goldafshani 2003, p. 602).

The dependability of the research process was upheld in regular meetings with the research supervisors throughout the project. The interview tool was developed from those used in previous studies exploring recruitment and retention in other rural health workforce disciplines, and government workforce surveys that had been conducted for practice nurses in Australia to achieve demographical attributes and qualitative data.

Transferability to a like situation and setting can be identified by the reader in the information provided throughout the research thesis. The literature review, research methods and research findings have provided insight into rural health workers and practice nurses in other settings. This allows the reader to compare the specific situations of the healthcare and rural context and/or methodology. This may be familiar to the reader, however, the results from this moment in time in the lives of practice nurse participants are not transferable (Colorado State University (CSU) 2011).
Ethical Considerations

An application for human ethics approval for this research study was submitted for review by the Human Research Ethics Committee, University of Wollongong. Approval was granted on 19 September 2008, HE08/231. The participant invitations were organised shortly after this time, within a few months. At the Dean of Health and Behavioural Sciences discretion, the Primary supervisor was changed from Professor Patrick Crookes to Associate Professor Janette Curtis in July 2009 and approved through an addendum with the Human Research Ethics Committee.

Ethics has been carefully considered in this study. It has been important to minimise the impact of the values of the researcher to ensure that participant ‘truth’ and ‘reality’ is accurately described in the findings (Davies & Dodd 2002, p. 280). This has been achieved by providing transparency, not only with research supervision, but discussion with research supervisors about the methods used within the methodology of this qualitative project. It is important for the researcher to understand that ethics involves trustfulness, openness, honesty, respectfulness, carefulness and constant attentiveness, to ensure that the research is not only rigorous, but to be accountable for the knowledge that is generated in the findings (Davies & Dodd 2002, p. 280). The researcher acknowledges National Health and Medical Research Council (NHMRC) guidelines (2007) and the University of Wollongong Code of Practice – Research (2007) for responsible conduct that fosters ethical research. The research environment of intellectual honesty, integrity, and scholarly and scientific rigour was maintained with the support of supervisors.

All data have been de-identified using pseudonym names for the nurses interviewed and has not disclosed the exact location of the research. This ensures that participant identity cannot be linked with the response data collected from interview transcripts. The researcher acknowledged in the participant information sheet a burden of inconvenience and expenditure of time for the participants to take part in a 30-45 minute interview. This had been explained on the participant information sheet and reiterated on the written consent form. The nurses invited to participate in this project were also advised that no information gleaned in this
research will be disseminated in a manner prejudicial to the interests of participants. The written participant consent prior to interview was attained and evidences the participants’ willingness to volunteer for interview. The participant information sheet (PIS) ensured that the participant was fully informed of the cost to their time, and information on the how the data will be used, stored and published. The PIS ensured participants were adequately advised of the nature (including the risks and burdens) of the research and are sufficiently free to make the decision to participate or to refuse to participate, and were prepared to be interviewed at a mutually agreeable place. The refusal or withdrawal of the nurse participants could be done at any time in the research process without fear of retribution or punishment. Voice recordings, transcripts and data details have been stored in a locked cabinet within the School of Nursing, Midwifery and Indigenous Health, University of Wollongong, and will be kept in accordance with University’s Code of Practice (UOW 2007) for at least five years, after which time they will be destroyed.

**Summary of method**

This chapter has described the research method incorporating the processes used to carry out this study. It provides insight into the underpinning philosophy of why a qualitative method was adopted and the development of the interview data analysis tool. Information on rural practice nurse participant recruitment, an overview of the data collection and semi-structured interviews to gather recorded data that was then transcribed. The qualitative data analysis was described within a rigorous six phase process (Braun & Clarke 2006), requiring exploration followed by thematic analysis to interpret the findings in terms of significance and meaning to meet the objectives of the research study. The validity, reliability and dependability of the study were discussed. The ethical principles in responsible research including participant confidentiality and anonymity have been described. The next chapter of this thesis will present the findings of the thematic analysis.
4. Results and Discussion

Introduction

This chapter presents the results and discussion of this small qualitative study exploring the social and professional issues that affect the retention of rural practice nurses. The reader will be presented with an overview of the research method: a thematic analysis of data from interviews that were conducted with practice nurses working in rural communities on the south coast of New South Wales in 2008 and 2009. Following an overview of the method, there will be a discussion of the participants’ demographics. A comparison of the demographical characteristics has been made between participants and the Australian practice nurse population at the time interviews were conducted.

Each of the four key themes that emerged from the data will be described: striving for professional recognition, grooming nursing services to meet needs, being ‘good for business’ (making money), and mastering the art of living. The results of each of these themes has been related to what was known in existing literature and the new findings that have emerged as a result of this study. At the conclusion of this chapter an exploration of the findings is related to firstly, the relationship between the social aspect of the rural practice nurse role and nurse satisfaction, and secondly, the relationship between the intrinsic and extrinsic professional aspects of the rural practice nurse role and nurse satisfaction. Together, these findings provide new evidence that can be adapted to strategies to improve the retention of rural practice nurses.

The Results and Discussion Chapter has been integrated into the one chapter in this thesis by the author. As this was an explorative study, the collation of both the qualitative results and discussion has allowed the emerging data to be descriptively linked to categories and the evolution of the themes. This has allowed the author to provide a concurrent reflective discussion on what was found in this study, which was then compared to what was known and unknown previously in the literature, and the significant implications for the future.
Overview of method

Interviews were conducted with seven practice nurses working in rural communities in New South Wales between 2008 and 2009 to explore social and professional issues that affect the retention of rural practice nurses. Week, on days off, or within the practice nurse schedule, disparities reported in the transcription. A thematic analysis of the data were conducted with the support of NVivo 7 software. Please refer to Method Chapter on pages 53-9 for further information on the data collection and analysis. The results identified the demographics of the practice nurse population, which has been compared to the Australian practice nurse population at the time participants were interviewed, as well as four key themes.

Demographics of the participants

Demographics were collected to compare the participants in this study to the practice nurse population; this included participants’ age, postgraduate nursing qualification/s, years practising as a nurse, years practising as a general practice nurse, and staff ratios. A comparison was made between the participants and the data from the AGPN National Practice Nurse Workforce Survey Report 2009 (AGPN 2009), and the APNA National Survey of General Practice Nurses: Salary and Conditions (APNA 2008) to determine any differences in the participants from a rural area and the general practice nurse population at the time of the study. A brief overview of the characteristics of the individual participants has been provided in Appendix 3 on pages 138-9. The AGPN (2009) study is significantly larger than the small number of participants in this study, as the AGPN (2009) study represents the responses of 1586 nurses in 826 practices, and therefore cannot be truly comparative to this study (AGPN 2009, p. 8)

All participants are female registered nurses, with six out of seven discussing responsibilities in caring for children at home. These findings are consistent with the AGPN (2009 p. 23) reporting that 98.2% of practice nurses are female. All the participants were registered nurses, a higher proportion than the AGPN (2009, p. 8) survey which reported 84.8% of practice nurses as registered nurses, 15.2% enrolled nurses.

The average age of the participants was 41 years, with a range from 27 to 48 years, and was comparable to the AGPN survey in 2009 which identified 79.7% of the practice nurse workforce aged over 40 years old with an average age of 42.3 years (AGPN 2009, p. 8).
None of the participants indicated they were seeking retirement, and intended to be practice nursing for many more years. There were no participants over 50 years of age, despite the AGPN (2009, p. 22) survey reporting that 35% of registered nurses in general practice were aged between 50-59 years. The participants were generally younger with four participants (57%) aged between 40-50 years, compared to 79.7% over 40 years identified by the AGPN (2009, p. 22). Six of the seven participants related the need to work hours that facilitated the fulfilment of family commitments for dependent children living at home. There was no comparative literature at the time of this thesis about child dependants of practice nurses; however, the nurses are all in an age group where child bearing and/or rearing could be expected.

In order to determine the stability of employment of the practice nurse workforce in this study, the length of each participant’s employment in general practice was reviewed. The mean length of practice nursing experience was six years (range three to 15 years), with an average of 16 years (range four to 24 years) total experience in nursing. When the participants were grouped into years of experience in practice nursing, there was one participant (14%) with less than one year experience, which was comparative to the AGPN (2009). There were two participants (43%) that had between two and ten years experience, which was less than the results of the AGPN (2009, p. 23) who found there were 60% of practice nurses with two to ten years experience. Two participants (28.5%) had greater than ten years in practice nursing, making the participants in this study comparatively more experienced than those reported in the AGPN (2009, p. 24) at 21.7%.

All participants worked within normal business times of Monday to Friday between the hours of 0900 to 1800. The nurses did not work weekends, after hours, on-call or in an additional workplace. In this study, two practice nurses worked full-time and five worked part-time. The AGPN (2009, p. 23) survey indicated that the majority of practice nurses are employed on a part-time or casual basis. The percentage of nurses working full-time in this small study was nearly double the AGPN (2009, p. 23) statistic of 20.4%. The participants worked a mean of 30 hours per week (range 16 to 40 hours per week). The AGPN (2009) had not surveyed the average hours of practice, however, a study by Joyce & Piterman (2009) exploring the practice nurse role in 2007, from a cohort of 115 practice nurses (45.2% rural and remote nurses), identified practice nurses in their cohort worked an average of 26.2 hours per week.
No participants were engaged in any other paid employment despite reporting low remuneration; however, the AGPN (2009 p. 24) survey found that 32.3% of practice nurses were employed in at least one other nursing job.

The participants travelled an average of 17.1 kilometres to work (range of two to 60 kilometres). The travel time (up to an hour from their workplace) varied for some participants in peak holiday periods due to visitors to coastal villages in the region. There were no comparative studies available at the time of this study that identified practice nurse travel to the workplace.

In terms of the participants’ initial professional nursing qualification, one participant (14.3%) trained at a rural hospital, whilst five participants (71.4%) were provided general nurse training in a metropolitan hospital and one participant (14.3%) was educated at a metropolitan university. The post registration qualifications held by participants included two qualified midwives (28%) and one palliative care postgraduate certificate (14%), making a total of 42% of participants with formal postgraduate qualifications. Postgraduate nursing qualifications were reported by AGPN (2009, p. 26) as held by 64.6% of practice nurses surveyed. None of this study’s participants had attained a postgraduate certificate/degree/diploma qualification since becoming a practice nurse, however, five participants (71%) had completed professional development courses since taking on the practice nurse role. These courses included Well Women’s screening, accredited nurse immunisation, ear syringing and infant feeding.

The headcount of staff ratios in the general practices where the participants worked averaged five (5) GPs to three and a half (3.5) practice nurses and six (6) clerical staff. The range of GP numbers in the participant’s workplace was one (1) to 12, and the practice nurse numbers ranged from one (1) to six (6), with the number of clerical staff ranging from two (2) to 15. The practice nurse ratio in this study was above the average when compared the AGPN (2009, p. 17) survey which found an average of one (1) practice nurse to two point zero one (2.01) GPs (headcount). These findings are important and could suggest there is a greater reliance on rural practice nurses to support the GP workforce shortage in this rural area. The geographical area of this project has been determined as an ‘area of need’ and thus attracts
funding which entices and supports GPs as there was a significant rural GP workforce shortage at the time of this study (PHCRIS 2009).

The average number of clerical staff employed in the participants' general practices was nearly twice the full-time equivalent number of practice nurses. It is unclear if the increased clerical staff numbers are related to a greater volume of paperwork/clerical tasks/clients associated with the current Medicare funding structure especially for those GPs who employ practice nurse/s, or if it is related to a GP workforce shortage, or if the participating general practices have labour intensive paper-based medical records rather than computerised record systems.

Themes

The findings of this study have been collated from categories, into sub-themes, into themes using a thematic analysis where similar issues/topics were grouped in the analysis, from semi-structured interview data and the meaning expressed within the data. For example, as presented in Table 4.1 on page 55, demonstrates the categories ‘GP encouragement for learning’ and ‘Cost of education’ were grouped together because they both originated from the same data segment that best described how learning on the job evolved, and addressed the research question regarding how education was attained for the practice nurse role.
Table 4.1: An example of segmenting and coding of the data

<table>
<thead>
<tr>
<th>Textual Data</th>
<th>Data Segmentation</th>
<th>Category</th>
</tr>
</thead>
</table>

Q: Explain what formal education you have had to prepare or support you in the practice nurse role?

P22. “I’m always asking him questions…we sort of throw our ideas off each other as well. He’s [GP] learnt this, or he read this, or he was at this conference, or I’ve learnt this, or I’ve learnt that and we share our ideas, so we have to keep learning. If you don’t you may as well leave.”

(Christine: p6, 183-187)

The nurse identifies an education need

The nurse identifies an education need

The GP is willing to support nurse learning

The GP is willing to support nurse learning

The GP is willing to share knowledge

The GP is willing to share knowledge

Access to education is linked to satisfaction

Access to education is linked to satisfaction

Learning on the job

Learning on the job

GP encouragement for nurse learning

GP encouragement for nurse learning

Education needs

Education needs

Cognitive maps provided a means of streamlining and refining categories and the clustering of sub-themes into themes. The themes were then reviewed, defined and named. The themes
were critically reviewed to ensure there was little overlap, and then related to the research question (Braun & Clarke 2006, pp. 91-92).

The cognitive mapping used throughout the thematic analyses is provided in tables within each theme. Table 4.2 provides a description, like a map, to guide the reader throughout the evolution of the themes from ‘Categories’ into ‘Sub-themes’ and into ‘Themes’. The same layout is utilised in each of the tables 4.3, 4.4, 4.5 & 4.6, in used to identify the emergence of each theme throughout this chapter.

Table 4.2: Evolution of themes from ‘Categories’ into ‘Sub-themes’ and into ‘Themes’ (O'Leary 2005, pp. 197-198)

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-themes</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>From the raw data, words and phrases are explored from repetition or through their context and their usage. Categories are collated from key words/phrases.</td>
<td>The key words/phrases are explored and compared in relation to concept and meaning to identify similarities and differences and these are grouped into sub-themes.</td>
<td>Following identification of the sub-themes, they are grouped into themes by exploring the relationships and connections between the various sub-themes to the relevance of the projects aims.</td>
</tr>
</tbody>
</table>

The four key themes are: striving for professional recognition, grooming nursing services, being ‘good for business’ (making money), and mastering the art of living. Together these themes provide insight into the professional life journey the nurses have experienced since becoming a practice nurse. Within a discussion of each of the four key themes, there is a table, this maps the emergence of each the theme, from their associated categories and sub-themes.

The literature review identified that practice nursing is a relatively unknown area of clinical expertise, and findings from participant interview responses has provided great insight into what attracted them to practice nursing, what keeps them satisfied and the challenges and difficulties they face throughout the evolving role. For the participants, the greatest personal satisfaction was achieving a life-work balance as practice nursing suited family commitments, with time to enjoy living in the rural community. The challenges and difficulties the participants discussed were predominantly in professional recognition and growth, as they described how they developed strategies to build a rapport with the GP and clients, developed and groomed their roles to fulfil the needs of the general practice in line with ongoing changes in Medicare fee structure. The participants described how they needed
to adjust their mindset from the public health system towards a focus on business, which needed to be both profitable and provide a healthcare service to the client.

The participants’ satisfaction has been expressed in terms of their sense of accomplishment in fulfilling the service needs of the role: feeling confident and competent in the role, feeling professionally valued and respected and having emotional wellbeing in achieving a life-work balance. There was a high level of satisfaction experienced by participants when they felt respected, integrated into a collaborative team, educationally prepared with adequate skills and knowledge with adequate infrastructure support.

**Theme 1: Striving for professional recognition**

The first theme, striving for professional recognition, evidences the professional journey that the participants described from first starting practice nursing to the time of the interview. The theme encompasses two sub-themes: firstly, adapting to a change in nursing context, and secondly, developing a new identity in general practice.

To adapt to the change in nursing context of general practice the participants describe how there was a shift of culture and attitude that needed to be developed to work in the unfamiliar general practice setting: the unknown diverse nature of the practice nurse role, the unmet expectations of the GPs and the strategies to deal with the expectations of the role. Good communication was pivotal to those participants who were new to the role, and this was a key starting point on the pathway to develop acceptance as a professional general practice ‘team’ member.

The transition into the practice nurse role was not easy, as the participants spoke about feeling torn from the culture they had known in public health, to developing a new identity as a practice nurse in the private healthcare business of general practice. As part of their journey into practice nursing the more experienced practice nurses who had previously worked in the hospital setting described how they needed to move on from initially feeling a sense of abandonment from hospital-based colleagues, who had “misunderstood” the general practice role as it was not seen to be “real” nursing. However, the participants then described an
ongoing struggle to feel valued as a health professional within the general practice team, as they felt they were inadequately renumerated when compared to other nursing settings. Table 4.3 provides a map that describes the emergence of categories, sub-themes and the theme of striving for professional recognition.

Table 4.3: Mapping of categories, sub-themes and the theme ‘striving for professional recognition’

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-themes</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP trust/rapport</td>
<td>Adapting to a change in nursing context</td>
<td>Striving for professional recognition</td>
</tr>
<tr>
<td>Working with GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse/GP communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture of GP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team collaboration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP control education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medico-legal concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting professional boundaries with patients</td>
<td>Developing a new identity in general practice</td>
<td></td>
</tr>
<tr>
<td>Gaining respect and professional recognition from patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fitting in with other practice nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional isolation: misunderstood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Different from hospital professional support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New allied health relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leave remuneration problems</td>
<td></td>
<td></td>
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<tr>
<td>Nurse pay problems</td>
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Adapting to a change in nursing context

In the sub-theme, adapting to a change in nursing context, the data identified that initially the participants needed to overcome some barriers from which they developed new roles and skills to complement the GP. Some practice nurses needed to adapt communication skills to act as the interpreter between client and GP, others noted the GP did not like to do tasks such as Papanicolaou smears (commonly referred to as a Pap smear), which may have been related to defined gender roles within the GPs dominant culture, and nurses performed these roles. Three participants described how the GP they worked with, completed their medical degree in a country other than Australia, and had, a different cultural background from that of the dominant Anglo-Saxon in Australia. Further they had a broad accent as English was not their
primary language. Participants were not reporting racist comments rather describing examples of difficulties they had communicating to GPs new to the Australian context and how they managed to overcome these problems.

One nurse identified that she was often misunderstood due to language, a:

*barrier because of culture... the beginning it was like “oh I don’t know what he was... he wouldn’t understand what I was saying and I anyway [sic] and it would be a lot of misunderstandings* (Mandy: p4, 122-123)

One participant identified that their practice did not employ doctors from different cultural backgrounds; in order to meet the community’s expectation that there will be an Anglo-Saxon doctor. As a practice nurse and co-principal with her GP husband, she described how the practice she worked in preferred not to employ GPs who held strong religious beliefs or had broad accents citing that they would jeopardise the business, as their rural clients could not understand them:

*I guess a very succinct way of filtering out the doctors who come and work here as well, and also the people that are going to be accepted by the community in which we live... so this is primarily Anglo-Saxon sort of background... we don’t have strong ethnic community down here. So probably a Muslim, Asian doctor may not be readily accepted you know, so it’s just- and it’s not a point of discrimination it’s more about working, what works better having had various sorts of nationalities here.*

(Libby: p11, 335-343)

The various origins of the GPs can be related to the rural area where this study took place. It has been identified as an ‘area of need’, where overseas trained doctors are encouraged, with financial incentives, to support the workforce shortages of general practitioners (DoctorConnect 2009). At the time of the study, New South Wales health policy identified that all medical practitioners who have received medical training overseas, whether they are temporary or permanent residents, are eligible to apply for vacant area of need positions under the 2009 NSW Health Area of Need Program. The term ‘culture’ has been defined as a sharing of similar values in traditions, history, knowledge and understanding of rituals, customs, languages and food, and other facets that determine one group of people from another cultural group (Kelleher & MacDougal 2009, p. 380). For healthcare to be efficient in
the rural general practice setting there need to be systems to support the understanding of healthcare workers who come from a different culture and who are submerged into the setting at the local level. At the time of writing this thesis, there are no courses to assist rural practice nurses unfamiliar with diverse cultures of overseas trained GPs who did not have English as their primary language, recruited to rural general practitioner roles, which may assist nurses in their role preparedness. DoctorConnect (2009) offer English language courses for GPs in the nearest capital city (Sydney, two and a half to three hours travel away) weekly for foreign GPs responding to area of need positions.

Generally the participants felt that good communication was pivotal when working in a collaborative team care role with the GP. Elements of collaborative care incorporated teamwork between the nurses and the GP with intertwining of roles in shared patient care, particularly in care planning. Nearly all of the participants discussed how they appreciated the feedback from GPs, especially when the GP expressed satisfaction with the nurse and when their work had added value to the business, and being able to free up the GP’s time to see other patients. The ADGP (2005, p. 6) demonstrate a business model in which GPs in a rural practice who employ a practice nurse can see an additional 16 patients per day.

Four of the participants carried out cervical Papilloma (Pap) smears for the GPs as the GPs preferred to attend other patient’s needs. Participant satisfaction emerged in the clinical collaborative working relationship with the GP. Six of the participants used key words to describe this, such as “respect”, “trust”, “autonomy” and “teamwork”. Six of the seven practice participants felt valued by the GP. One participant felt really valued and respected, and was described as the “first hand lieutenant” by the GP.

All nurses had a generalist role as, over the day, their tasks were very diverse. However, they were pleased when the GP valued their expertise in particular areas. For example, Vicki had expertise in wound dressings and emergency care; Michelle and Libby both had midwifery experience and attended routine antenatal screening prior to the doctor seeing the patient, four participants attended all Well Women’s health checks (including Pap smears); and Christine enjoyed providing emergency care.

I’ve had to learn different things and because of the general, you know because our roles changed and because of the accreditation …… you know
from compared to when I first started ... in Sydney the things that we do now in General Practice ... is just different, ... you have to do more. You know like the recalls it’s not just the stock ordering it’s um you know you have to make sure the fridge – you know the temperature of the fridge is right. You have to make sure the doctors bags orders are there. ...the expiry dates on all the drugs are you know .... we’ve had to learn and ...and plus the um the chronic disease EPC management stuff and the health assessments ... I’ve being doing them now for about I suppose four years, four or five years since it started. (Vicki: p116-130)

Only one participant, Amelia, felt devalued in her relationship with the GP. This may be related to reduced confidence and knowledge as she described her role as “handmaiden”, despite practice nursing for three years in the same practice. Despite trying to build and develop a new workplace culture that supported the practice nurse role, she felt frustrated by the lack of professional respect:

... I’m so incredibly frustrated by... lack of support, ... lack of time for studying, ... lack of understanding as to what my role actually is, lack of job description... forever getting asked different things, for different expectations...” (Amelia: p8, 257-262)

The nurses enjoyed a collaborative team approach where there was a balance between working independently as well as part of a team with the GP, where the GP provided a supportive environment. The nurses enjoyed contributing to developing strategies to improve patient services, whilst building up the practice business. Vicki felt she had contributed to a very successful general practice business by identifying her skills were “part” of the services that added value to the business.

One participant felt that it was the partnership [that] built the practice up from nothing (Libby: p12, 377-381), together with a very nurturing and supportive environment... rather than it being more a dictatorship where the orders come down from the top (Libby: p10, 310-316).

However, for three participants there was anxiety about their professional reputation in the community if anything was “to go wrong” medico-legally, as they were unsure if they would
be supported by the general practice. One concern related to occupational health and safety as the participant attended home visits unaccompanied on routine annual health assessments. She felt that her safety was compromised with some of the patients in their home due to the promiscuous advances some of the elderly gentlemen had made, and was also concerned about what she might do if she found someone dead. Whilst she had reached a compromise with her employer, she felt she should have the right to refuse home visits and see all clients in the surgery. However, the GP insisted she needed to continue doing home health assessments because of the higher Medicare rebates that could be claimed for home-based health assessments than those conducted in the surgery.

*I think that there’s so much money going into those that it’s so bad and this doctor knows it, and I am bringing in – him in oh 15 hundred dollars just from health assessments in those three days if not up to two thousand and I just think, for what they are, you know and if you’ve done it every year for the same person, I just don’t think that they’re totally vital for that amount of money.* (Mandy: p 10, 320-326)

This participant also raised privacy concerns in the surgery, which was an old house, where she shared the same room as the staff tea room where she had difficulty maintaining patient dignity without any curtaining or privacy screening in a room also used by other staff as a tea room and store room.

Another participant enjoyed the “lack of red-tape” in her role, however, was concerned when she reflected an uncertain medico-legal position should something go “wrong”:

*I don’t think I’d want to do anything wrong or else I would be out tomorrow, but while everything’s are going good it’s um, it’s nice, it’s good, it’s very supportive.* (Jane: p8, 262-264)
Developing a new identity in general practice

This sub-theme, developing a new identity in general practice, emerged as the participants found some of the most difficult challenges for the nurses was to prove their worth, add value to care delivery with expanded knowledge and skills (particularly in chronic disease care planning), and in establishing respect and trust with their unique professional identity in an environment that was not always familiar with the nurse role. The participants described how they had to “plough through” in developing their role to attain professional recognition, acceptance and respect from both GPs and patients. Participants described unease, but felt it was important to set professional boundaries with clients who were known and who were part of their community.

All participants raised the need to be accepted by and belong within the community in which they work. The majority of practice nurses enjoyed feeling trusted, respected and identified by clients within their community. One participant particularly felt it was important to build trust and rapport with the clients, likening her clients’ behaviour to that of animals:

[clients] bum sniffing like cats and dogs do, like getting to know me, and accepting me and building a relationship... they need to learn to trust me... It’s not just being the nurse, or that nurse (Christine: p8, 253-254)

The participants felt supported by their client when trust and rapport was elicited, and sought an affirmation of client rapport. Once this support was attained, the participants felt satisfied and accepted in the role of health professional in the practice.

One participant saw her role as being an integral part of the GP service:

I’m an extension of his arm and people would look to me providing much the same service (Libby: p6, 172-174)

Understanding, knowing and addressing the clients’ needs provided great satisfaction to the participants. The participants affirmed client confidence when the clients referred to them as “my nurse”.

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Vicki felt practice nursing was “*a privilege*”, and enjoyed when the client was “*so confident*”, they wanted to “*talk*”. It was important to the participants to “*make a difference*” to the clients “*little world*”.

The participants felt that as a practice nurse you need to  

*earn a little bit of respect... in the community... to know you're valued by the community* (Vicki: p8, 257-262), and that as a practice nurse you become intrinsically *part of the community as opposed to being an outsider* (Christine: p5, 133-137).

A few participants felt that knowing the community meant there was a lack of anonymity, and this had its downside. One participant felt you always want to say hello to the client but “sometimes… you embarrass people” such as a client you just did the Pap smear on who sees the same nurse later in the supermarket (Michelle: p9, 268-272).

In the literature review, loss of anonymity was problematic for rural nurses as 36% of rural nurses resigned in Queensland because of the emotional demands associated with loss of anonymity (Hegney et al. 2002c). So far this study evidences the opposite to Hegney et al. (2002c), that being known within the community was an important factor for rural practice nurse retention. This can be related to long term relationships described by the practice nurses: how their families had embedded in their community, and that their patients, unlike rural community and hospital patients, general practice patients have a choice of which doctors surgery they wish to attend, and may choose if they wanted to see the nurse. For general practice, the holistic care that general practice nursing offers is provided over a lifespan, and often encompasses long term chronic disease management with many appointments over longer periods of time, where there is opportunity for the patient-nurse relationship to develop (Phillips et al. 2007).

Both Christine and Libby used words that demonstrated an understanding of the nature of rural patients: “*time-hungry farmers*”, “*stoic*”, “*private*” and “*proud*”. The participants recognised that often their clients had great distances to travel, or had transport problems getting into the surgery. Therefore, as nurses they had enjoyed the ability to provide timely and opportunistic care, both within scheduled appointments and in the provision of emergency care. The participants thought it was important to have a chat with the client to
check both physical and emotional needs, and identified that they were often the only person they had spoken to, especially for those who lived in isolation or who were carers who needed some support. One participant used the time waiting for the doctor’s review, or whilst attending wound dressings following health assessments and care planning, to check on “how they are going”, and this was important to her.

The need for clear professional boundaries was expressed by two participants (Vicki and Libby), they had been practice nursing for more than ten years. These boundaries delineated their professional responsibilities from their social life, in order to protect their professional integrity. Vicki described how she, her GP husband and family moved town to maintain a physical distance as a professional boundary. Vicki felt it was important not go to patient’s funerals and to distance her patients from her personal friends. The need to set professional boundaries should be very clear to clients, and this can be related to long-term relationships with patients.

I make a point of not going to people’s funerals and …and I think it’s important not to become um personal friends although we have become personal friends with one gentleman that that’s come to the Practice here but um you know I don’t make it a you know a habit of…. you know I just sort of um because my husband and I basically stick to ourselves… (Vicki p 16, 509-514)

Local knowledge of the resources available for clients, particularly knowing the allied health workers within the community, provided the participants with a tremendous feeling of satisfaction and professional acceptance. The allied health professionals that were cited by the participants were pharmacists, physiotherapists, diabetes educators, dieticians, podiatrists, and community health educators. The participants felt great satisfaction in knowing local health professionals who could best provide appropriate services to support enhanced primary care team care arrangements, supporting clients with chronic diseases. This was a very positive aspect as participants enjoyed sharing the client care with allied health professionals, which were a very important extension of the healthcare care services.

Peer practice nurse support was discussed by four participants, as they enjoyed the opportunity to network with fellow practice nurses. Networking encounters were described as either on the phone or personal face to face meetings. Five participants attended education
and training opportunities, usually after hours or in their own time, so as not to inconvenience or add a cost burden for their education on the general practice. The opportunities were organised predominantly through the local Division of General Practice. Other nurses enjoyed working with nursing peers in the same surgery.

The participants were disappointed as they felt nurses in other settings, particularly the hospital, misunderstood their role in general practice. Vicki thought her hospital peers viewed practice nursing as “not really nursing”; she believed this attitude was related to a lack of understanding of the practice nurse role.

This participant stated:

*I don’t think the nurses at hospital realised what... how... well educated we are. I don’t think, they have no idea, they just think that... what I do, or what practice nurses do, isn’t really nursing, so, but they have absolutely no idea*

(Vicki: p5, 137-141)

Another participant described how her nursing role sometimes seemed to be misunderstood by patients, especially when they asked when she was planning to go back to hospital nursing where there is “real nursing” (Libby: p12, 369-370).

In trying to be professionally recognised, all participants felt discouraged with their low remuneration and felt powerless, as the GP principal controlled their remuneration. Six participants voiced concerns where discrepancies were found in the practice nurse remuneration, funded out of the general practice business. Amelia identified that she would most likely return to hospital shift-work when her children were old enough because of the attraction of higher wages. Six of the seven participants identified that they were likely to remain practice nursing until their retirement as the convenience of family-friendly hours added to their quality of life and felt this compensated the low wages.

*I was sick of shift work and I wanted weekends off and because my children were little and um yeah just ...just basically quality of life with my family really – yeah. I just didn’t want to – yeah that was the biggest draw card really.* (Vicki p2, 40-45)
As discussed earlier in the literature review, the role of nurses in general practice remains in a period of evolution (Patterson et al. 2007; Halcomb et al. 2006). The misunderstanding by hospital nurses and clients may be related to a diverse generalist nurse role that is seen to lack transparency in the broad range of tasks undertaken by practice nurses.

Negotiating pay was stressful for four of the participants who felt uncomfortable asking for pay with no supporting practice nurse pay structure, and consequently, were paid lower than they had hoped. The lack of career pathway and low remuneration for practice nurses has been identified in APNA’s Salary and Condition Survey (APNA 2009). The low pay rate and lack of formal pay/career structure made one participant feel devalued in relation to pay, and confused as her colleagues with more experience should have been paid more than her:

\textit{in our workplace wages have been negotiated... but even compared to nursing in hospitals it’s just a kick in the face} (Amelia: p11, 333-335)  
\textit{how fair is that I’m getting paid the same amount as one of our other nurses who’s been nursing for nearly 25 years, who has so much experience behind her but is doing the same role as me} (Amelia: p12, 366-369)

There were no remuneration concerns expressed by one participant who worked in a dual role by being involved as both business manager and practice nurse in the business she shared with her GP husband and thus presents a bias due to her conflict with her management role. Two participants did not know their leave entitlements as they had no pay slips, despite working in the same practices for five and three and a half years respectively. Jane was restricted to taking holidays for a maximum of two weeks at a time, at a time that suited the principal GP who took his holidays in the same period.

Sick leave relief often came from other practice nurses within the same practice, as they covered for each other. The participants who worked with other practice nurses enjoyed the flexibility this brought, especially when their children were sick. The participants seemed surprised when they realised there was a lack of transparency, as all participants had a verbal employment agreement with unclear conditions, which had not been encountered in previous nursing employment. In the literature review, it was noted in the APNA 2008 survey (APNA 2008) that practice nurses were less satisfied with pay than their colleagues working in other
sectors. The nurses described the importance of being recognised with professional remuneration that incorporates educational support, travel support, and a pay structure.

**Discussion of Theme 1: Striving for professional recognition**

The nurses described the journey they had undertaken professionally since coming to the rural general practice. The professional challenges they needed to overcome to accept and adapt to the diversity of the general practice: the culture and attitudes of the GP, to gain the respect and trust of clients in the community and the GP, and overcome the stress and tensions associated with developing a new identity as a practice nurse whilst feeling isolated from their previous work setting. With unclear role descriptions and little opportunity to network with other practice nurses, the nurses developed their new role to “fit in” with the needs of the practice. The practice nurse need to adapt to the unfamiliar role in general practice has been identified in previous literature (Cross 2006; Halcomb et al. 2006).

Nurses discussed their struggle initially to gain trust and respect from their overseas trained solo GPs, who they felt did not understand their role. A good working relationship between the nurses and the GP meant supporting shared patient care where good communication made for good teamwork. Nurses felt their GP expressed satisfaction when their work was good for the business and/or freed up the GP’s time. Practice nurse satisfaction in this study related to collaboration with the GP, similar to outcomes found by Halcomb et al. (2008) exploring collaborative care in general practice. The current New South Wales health policy in relation to ‘area of need’ staffing needs is yet to consider the impact of communication barriers and develop appropriate strategies in the communities where doctors are servicing.

Most practice nurses identified that they were likely to remain practice nursing until their retirement as the convenience of family-friendly hours add to their quality of life, and predominantly compensated for their lower wages. In a study conducted by Phillips et al. (2009) flexibility in nurses’ hours was important and made the practice nurse role attractive. It was important to establish professional rapport with clients. Trust and respect from the community has been cited in health workforce studies by Hegney et al. (2002 (a) & (b)), Harding et al. (2006), and Hayes et al. (2007).
The nurses were concerned that their role in general practice is misunderstood by nurses in other settings and by patients as “real” nursing was thought to be hospital-based. The isolation of nurses from their peers had been identified in studies by Halcomb et al. (2005) and Patterson (2000).

Two nurses were worried about their reputation in the community, particularly if anything was to go wrong medico-legally, and they were unsure if they would be supported by the general practice. Medico-legal ambiguity was identified in reviews of practice nursing roles by Nowark & Bickley (2005) and Murray & Wronski (2006).

Rural practice nurses identified a need for improved remuneration and a pay scale as a need and these concerns have been found to be rhetorical since 2004 through until the Salary and Conditions Survey conducted by APNA (2009). Another concern for rural practice nurses was the lack of transparency in the sick leave and holiday entitlements, which were not identified in employment agreements. From 2010, the Australian Government has set clear expectations for employers with the National Employment Standards (NES) where there is a safety net of minimum terms and conditions that align to the Fair Work Act 2009 (Fair Work Ombudsman 2009).

**Theme 2: Grooming nursing services to meet needs**

The second theme, grooming nursing services to meet practice needs, incorporates two sub-themes: preparing for the new generalist role expectations and learning on the job.

In the first sub-theme, preparing for the new generalist role expectations, the participants were not necessarily prepared for the practice nurse role and that role was constantly changed. This change was found to be related to the adaption of previous experiences of the nurse to the role, and the nurse role expectations of the GP associated with the changes in Medicare Items numbers, particularly in the management of patients with chronic disease. The initial anxiety of the participants was seen to reduce their satisfaction until they were familiar and felt confident with the role they “groomed” to suit their areas of interest, expertise and one which met the needs of the practice. The participants’ previous experience
in general practice varied and this was evident in the interview data, as they described the struggle to seek information on the changing role expectations in line with Medicare item numbers, particularly for chronic disease care. The participants came from varied backgrounds: two nurses from hospital wards, one participant from community health, one participant from a maternity unit, one participant from military nursing, and two participants were previously general practice nurses. The participants’ previous field of expertise depicted their key interests and were initially pursued in practice nursing. With professional growth from experience and education, the participant’s role was individualised, “groomed”, adapted and moulded to suit the practice needs.

Generally the participants identified that they needed to embrace the challenges of change in order to diversify and refine their skills beyond the generic role, to extended and advanced practice roles. These roles required greater clinical decision making in “mini emergency department” treatment rooms and nurse-led clinics in consulting areas.

In the second sub-theme, learning on the job, the data identifies that participants needed to learn on the job. They particularly enjoyed support and encouragement from the GP which, for most, was ongoing throughout their journey as a practice nurse. The participants sought education from a variety of resources: GP, visiting drug representatives, practice nurse meetings, the Division of General Practice, formal face to face meetings, online learning and reading literature. The majority of participants felt they needed to extend their knowledge and skills to perform tasks competently, and expressed difficulties in accessing adequate education and training due to lack of GP support, the cost, the distance, and time away from family. Table 4.4 provides a map that describes the emergence of categories, sub-themes and the theme of grooming nursing services to meet needs.
Table 4.4: Mapping of categories, sub-themes and the theme ‘grooming nursing services to meet needs’

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-theme</th>
<th>Theme</th>
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<tr>
<td>Nursing background</td>
<td>Preparing for the new generalist role expectations</td>
<td>Grooming nursing services to meet needs</td>
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<td>Unpreparedness</td>
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<td>Expectations of GP</td>
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<td>Expectation of patients</td>
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<td>Making do with what there is</td>
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<td>Dealing with broad role expectations</td>
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<td>Diverse nursing skills</td>
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<td>Being flexible</td>
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<td>Generic role task</td>
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<td>Extended role task</td>
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<td>Advanced role task</td>
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<td>Changing Medicare requirements</td>
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<td>Clinical decision making</td>
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<td>Nurse-led clinics</td>
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<td>Mini emergency departments</td>
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<tr>
<td>Learning on the job</td>
<td>Preparing for the new generalist role expectations</td>
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<td>GP encouragement for learning</td>
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<td>Cost of education for nurse</td>
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<td>Distance of education</td>
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<td>Education needs</td>
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<td>Other education sources</td>
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<td>Education local sources</td>
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<td>Government support for education</td>
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Preparing for the new generalist role expectations

The participants discussed that their role was not only challenging educationally, but very diverse. There was no typical day described by five of the participants, rather a day consisted of set tasks combined with emergency care and triage. Two participants had very set schedules and tasks and did not describe a triage or emergency care role in their practise. All participants identified that they cared for clients across the lifespan, from young infants to the elderly. The participants found this very challenging at times, as they were not necessarily prepared for diverse generalist skills and or with knowledge to work within the scope of nursing practice.
The participants discussed how it was important to seek support from the GP, colleagues, drug representative and the Division of General Practice for extra knowledge and skills to perform their roles. From initially starting in their current role, the education they had received. It had facilitated improvement in both personal satisfaction and professional development. It had given them the tools to groom their role with professional growth which prepared them to work in advanced roles such as running nurse-led vaccination and Well Women’s screening clinics.

One participant really enjoyed the variety and autonomous role she had created:

_“I feel like I’m nursing... a lot of variety... and I’m quite autonomous... I can do as much or as little of the roles as I want to, I can groom it to my liking within certain limits I suppose... it’s really good in that way I think”_ (Jane: p11, 357-361)

The participants discussed how they were not necessarily prepared for the practice nurse role, despite hospital, community and military backgrounds. One participant who came from an operating theatre background felt she did not have 

_“any kind of qualifications related to practice nursing”_ (Amelia: p3, 84).

Vicki, who had worked with many GPs previously, identified that each new GP had different areas of expertise and interest, so she needed to change her role and consequently had ongoing education needs to support each new GP.

_“Each doctor you know likes things done differently so I’ve had to learn different things and because of the general, you know because our roles changed and because of the accreditation you know we’ve had to do a lot more so – yeah there’s, you know from compared to when I first started you know in Sydney the things that we do now in General Practice what you have do is just different...”_ (Vicki: p4, 115-120)

The participant who had worked in the military found the role unexpectedly diverse:

_“I think personally, I think it’s a bit of everything; it’s not just your nursing experience, personality... the way you deal with people as well. Typing skills... being able to multitask, assessing things on the flight, it’s not just about being a nurse; it’s about being a bit of everything as well”_ (Christine: p3, 69-73)
These participants described a “struggle” in formulating a new professional identity and adapting to the role expectations of general practice. Compounding the situation for three participants was the fact their GP had never worked with a practice nurse before they started, and these participants described how they needed to demonstrate the adaption of their prior knowledge and expertise to the new role. One participant (Amelia) discussed that orientation programs should be available for new practice nurses to upgrade their knowledge and skills necessary for the practice nurse role.

I can understand you know there’s an advantage in um having people in general practice that are experienced, however, like I feel like that there’s no … there’s no training um for young people in general practice, like young nurses so if you don’t have any experience you just kind of learn on the job, and quite recently I’ve been thinking that it would be nice to kind of talk to the Uni and say “you know can we work something out”..... because practice nursing is Medicare.. making all these item numbers available to …to practice nurses working either under supervision or on their own um and it’s going to be one of those things, like the same with (exodus) it’s going to happen in the public health system,.... (Amelia: p 3-4, 95-105)

The participants sought education and training in advanced wound care techniques, chronic disease management, immunisation, emergency care and triage, and health screening. The need for a diverse range of nursing skills can be related to a rural location as many rural nurses were found to feel obliged to undertake tasks as there were little localised support services from their small communities (Hegney et al. 2002b). Additionally, the lack of access to other healthcare support services for the participants in this study, particularly for emergency clients, meant that these participants had to learn skills to adequately care for the patients until they are seen by the GP and while they awaited emergency transport to hospital.

For the four participants who had previously worked in the community or in general wards in the hospital, emergency care caused anxiety and stress. One participant (Jane) from a community health background found dealing with emergencies, particularly involving children, was challenging, anxiety-provoking, and a challenge that she did not enjoy. This participant had no children or previous paediatric nursing experience. Another participant (Libby), despite practice nursing for ten years in rural areas, chose not to deal with the arrival of emergencies. Where possible, this participant relied on a new practice nurse and the GP,
both with emergency experience, to care for the emergency clients as they arrived to the surgery, and felt more comfortable caring for these clients after they were seen by the GP.

other emergency sorts of thing[s] …… The kids are probably something that I don’t feel real comfortable with at this stage, but I don’t know that any of the doctors feel too well with them anyway. Often if you …if you can win the parents over and keep the parents comfortable and leave them the role of looking after the kid I find it but does anyone – I don’t know there must be some magic people … some people that are probably better skilled at dealing with the screaming kid…. (Jane: p6, 185-192)

The three participants who had previous emergency care experience (Vicki, Christine and Amelia) were enthusiastic about the opportunity to provide triage and advanced nursing skills, and enjoyed the professional recognition and gratitude from other practice staff. The participants who dealt with the emergency clients felt their professional autonomy was restricted as, despite feeling competent and confident with the care they delivered, they had to wait for the GP to consult the patient. This GP consultation is a requirement by Medicare for the item to be claimed. This has been linked to the theme, being ‘good for business’ (making money), as the nursing service was to not only provide patient care, it also needed to generate income for the business.

I just don’t think that they’re [Annual Health Assessments] totally vital for that amount of money. I just … I just don’t see the need – yeah because they actually say to me “well I’ve just had … I just had a GPMP with the doctor and he had to do my height, weight and that then and so now patients are feeling like they’re just constantly being assessed, and oh it’s sometimes they just don’t want me to come and he wants me to do at least two a day, at least…. (Mandy: p 10-11 325-331)

The participants provided a diverse range of skills to cope with nursing services across all age groups, from infants to the elderly, for those with chronic and complex diseases (some of which were unfamiliar), receptionist duties, and the unexpected patient arrivals. Overall, the nurses were satisfied with the diversity of their day, describing the day as unpredictable and challenging. However, the nurses in this study had varying degrees of expertise, experience and confidence in managing a generalist role.
Amelia practiced as a “novice” practice nurse, with the beginning skills and knowledge in terms of education and level of competency (adapted from National Nursing and Nursing Education Taskforce (N3ET) 2006). The sorts of tasks described by Amelia incorporated wound care, minor surgical procedure assistance, basic health assessment (of activities of daily living and observations), and assistant to the GP with procedures. The other six nurses described extra knowledge and skills that required professional initiative with extended and advanced skills to facilitate client care such as care planning, IV cannulation, suturing and ear syringing. In advanced care the nurse attended nurse-initiated care such as conducting immunisation clinics, Well Women’s health screening (Pap) clinics and providing emergency care before the GP attended. As Amelia’s role was task oriented, there was little opportunity for her to initiate nursing actions.

In Appendix 5, on page 142, the table Practice Nurse Roles demonstrates the range of roles undertaken by the participants. As the nurses cited the tasks they performed, these were grouped into roles encompassing level of skills for advanced, extended, novice and non-clinical duties. This table also demonstrates the number of participants who performed these roles. Vicki and Christine, both with emergency backgrounds, really enjoyed the opportunity to deal with emergencies and felt satisfaction that this role minimises disruption to the GP schedules.

We do triage... a lot of the time... because the hospital here, there’s actually not a doctor on duty at the hospital. A lot of the emergency patients actually come to... to the local GP... so for example yesterday... one was an unstable angina... so I had to give him oxygen, do all his obs, put in a cannula, do all of his sats [oxygen saturation]... just exactly like you would do in an A&E department and then the doctor comes in... so I do all the groundwork and then the doctor comes in and says “ok, I think you need to go to hospital”... and an ambulance is arranged for transfer to a hospital [over one hour away] (Vicki: p11, 339-359)

The findings evidence nurse-led “mini emergency departments” in five out of the seven general practices in this study. Three practices clearly provided the facilities of “mini emergency departments” where emergency equipment was provided for moderate injury and illness management. In rural areas the general practice is often the first point of contact by
those requiring care and the practice nurse role is extended to a role similar to an emergency department nurse.

Most participants were surprised that there were so many ongoing changes and challenges in their role. The professional education they had consequently gained since first taking on the practice nurse role had facilitated change, not only in the level of personal satisfaction and professional development, but also in their roles. Many felt they had progressed with knowledge, skills and experiences to work in advanced roles, such as running nurse-led clinics in vaccination, INR (coagulation testing) and Well Women’s screening. Those nurses enjoyed the autonomy and appreciated the support of the GP for the nurse-led clinics. The nurses felt confident to initiate primary healthcare prevention and promotion opportunities with their client, and had been credentialed in immunisation and Well Women’s health screening.

**Learning on the job**

In this sub-theme, learning on the job, the participants described how they enjoyed learning on the job as it helped them cope with the diverse and complex care needs associated with the general practice setting. It also provided the participants with an opportunity to attend seminars introducing extended nursing roles such as ear syringing and plastering, and some of the tasks that the GP had traditionally attended such as Pap smears. When the participants felt confident to attend these tasks after formal and/or training by their GP, they felt it added to the quality of services they delivered in general practice. The GP was seen as the main education provider, often telling the nurses what they were expected to do, and the participants were not necessarily confident and competent to practice safely within their scope of practice. For example, administering cryotherapy, where liquid nitrogen is used to freeze skin lesions, especially pre-malignant skin spots. However, with the empowerment of education from the GP, the nurses described they enjoyed some ownership of their roles within the collaborative team. Christine stated:

> I’m always asking him questions... we sort of throw our ideas off each other as well. He’s learnt this, or he read this, or he was at this conference, or I’ve learnt this, or I’ve learnt that and we share our ideas, so we have to keep learning. If you don’t you may as well leave” (Christine: p6, 183-187)
Additionally, all participants had engaged in professional education that was episodic and convenient, from self-directed learning to reading literature on clinical medical/procedural guidelines in general practice. All participants felt that education and training by nurses for practice nurses at a local level was an area where there could be greater networking and education support from the government and professional nursing organisations.

Six of the seven participants had completed short courses, however, the participants felt disappointed about the limited financial and study support from their workplace. Most nurse education and training occurred outside their usual working hours. The personal barriers to ongoing education were after hours child care commitments, the personal financial burden of education course expenses, limited range of local education and training opportunities, and limited out of area financial support for education and training. The pursuit for professional education had become a frustrating process which reduced the participants’ job satisfaction. All the participants had come from health delivery services funded by the government where essential staff education and training for safe clinical practice was provided and funded as part of their employment package, and to pay for and/or attend education in their own time was seen to be a personal burden.

Two participants had an education fund that was set aside for practice nurse education limited to information linked only to Medicare funded care. This restricted their scope of practice to wound care, immunisation, Pap smear, care planning, health assessments and chronic disease support.

.....know that that’s the rules now you know I’ve got three lots of I suppose it’s 24 hours of training to do and he’ll pay me those hours to do that training and I guess depending on what the payment of the course is he will negotiate with me whether he’s going to pay for the cost of it or whether it’s a freebie anyway, but you know I think that’s fair and it makes me prioritise to you know about the things that I – he’s ...he’s certainly is more supportive for me to do the things that are actually going to support the business rather than things like that um – what’s the Beyond – not what’s the Well Women’s one, you know Beyond the Well Women’s one there’s a women’s health one isn’t there that you can do for fertility stuff and contraception and all that stuff, but if I ... but if I did that course I’d be encroaching on some of the stuff that the doctors do and there wouldn’t be any remuneration if I was doing that
sort of counselling with people, so yeah he doesn’t want me to do that even though I’m interested in it, and he wants me to do the domestic violence one but I’m not interested in that at all but don’t know that I’ve got a say... (Jane: p12, 395-407)

The two participants, one who came from a solo general practice and one who came from a GP-directed, task-orientated role, felt unsupported as the GPs they worked with were not willing to consider any education funding.

One participant who attended a funded two day Well Women’s health screening course in her own time felt disappointed that she was not supported for overnight accommodation and travel by the practice:

*I would like to learn more things and I know there’s like that practice nurse conference thing and you can go and you can do all these things, but one problem is that for me the doctor will not pay anything*... (Mandy: p5, 157-160)

*I would never do anything again that involved my time away from my children, you know away from my family to do something for work, unless I was paid for it* (Vicki: p7, 221-225)

The participant who identified she needed more formal training in cryotherapy stated that because it is not associated with any practice nurse item number the GP was not willing to send her on a course. In fact any courses, including nurse-initiated courses, had to be “justifiable” in terms of “benefit” for the business in order to recoup the expenses.

Sources that provided local education were the Division of General Practice, medical journals/guidelines/books, drug representatives and allied health professionals. All participants preferred to have their education and training delivered within the local area. The timing of the nurse meetings generally were not prearranged with management for those practice nurses belonging to a larger practice with two or more nurses. However, for a solo practice nurse, more formal settings like Division nurse meeting/educational sessions were seen to be very important to keep up to date with general practice changes. Three of the participants (Jane, Michelle and Vicki) acknowledged that whilst it was nice to go out of the area to a conference or course to meet other nurses and “learn new things”, it was difficult to manage child care commitments, expensive due to the fees, loss of wages, travel and
accommodation, and it was difficult to arrange time off from the workplace. Hall et al. (2007) and Meadley et al. (2004) identified that the majority of practice nurse education was largely informal through the workplace or Division of General Practice.

Vicki liked to attend workshops at night, to avoid any costs to the business:

“We do a lot of... workshops... but that’s in the evenings so that’s alright... you know they don’t have to pay or anything” (Vicki: p10 79-81)

The participants were frustrated when new Medicare incentives were made available without education and training within the timeframe required by the GP. Examples were cited by six of the seven participants and included waiting many months for a “domestic violence education workshop”, “four year old healthy child check”, wound care and diabetes education. There was an expectation from the GP for the participants to perform the tasks associated with the new Medicare incentive payments without waiting for the nurse education component.

Other educational opportunities arose from discussing disease and treatments informally with allied health professionals, drug company representative staff and general practice guideline books to provide information, particularly about chronic diseases. One participant described how the GP gave her books and advised the resources would be sufficient for the knowledge she required, as he did not support her to take time away from the practice to pursue further educational opportunities in her working hours.

Formal educational opportunities accessed by the participants were both online learning and face to face tuition with registered training organisations such as: Well Women’s screening by Family Planning Association (FPA) NSW, electrocardiogram and emergency training with Ausmed Education, immunisation course through distance education with The College of Nursing and the attendance of a professional conference with APNA. Six of the seven participants identified that the Australian Government offered education funding assistance through scholarship opportunities that exist for practice nurses. These include scholarships (usually for course fees and/or travel) for nurses to attend immunisation certificate and Well Women’s screening courses, facilitated through the Division of General Practice.
The personal barriers to practice nurses attending education, despite having opportunities in the evenings, were securing child care and the expense. Two nurses Amelia and Michelle had very small children and cited that it was difficult and expensive to get child care to attend evening education opportunities, as their partners were often not home. These were their greatest personal barriers. The cost of education and the cost of childcare has been identified by Meadley et al. (2004) as an educational barrier for practice nurses. The cost of education was an issue for all practice nurses interviewed. They cited they were paid less than the hospital setting due to lower hourly rates and/or no shift-work penalties and this restricted their educational opportunities as cost was a major consideration.

**Discussion of Theme 2: Grooming the role to meet practice needs**

The initial anxiety associated with beginning the practice nurse role was seen to reduce nurse satisfaction until they felt confident with the role they groomed to suit their areas of interest, expertise and one which addressed practice needs. The participants’ experience in general practice varied and this was evident in the data, as they described the struggle to seek information on the changing role expectations in line with Medicare item numbers, particularly for chronic disease care. Practice nurse unpreparedness was identified by Cross (2006) and Halcomb et al. (2009). The participants described the barriers they experienced in attaining the skills and knowledge that were expected within a role that continued to change and have been described previously by Wronski & Murray (2006) and Halcomb et al. (2005). The participants’ field of expertise depicted their key interests when initially practice nursing and then the role was adapted and moulded to suit the practice needs and the new education the nurses attained.

The need for a diverse range of nursing skills can be related to a rural location as many of the practice nurses felt obliged to undertake tasks as there were little localised support services for their small communities. There were similar concerns identified in rural GPs by Denham & Shaddock (2004) and Hays et al. (2005).

This study found a new major component of the rural practice nurses role was emergency care and triage. Compounded by the lack of these support services, particularly for emergency clients, meant that nurses must have the skills to maintain a standard of care until patients are seen by the GP prior to transport to hospital or treatment. However for the nurses
who had no experience in emergency care, particularly nurses who had previously worked in the community or in wards in the hospital, this caused great stress and anxiety. The practice nurses that had previous emergency experience seemed to thrive on the opportunity to triage and utilise their advanced nursing skills, and enjoyed the professional recognition of their skills amongst the surgery staff.

The participants described a diverse range of skills to cope with tasks for all age groups, from infants to the elderly and a broad range of chronic diseases, receptionist duties, and the unexpected patient arrivals were articulated by the practice nurses. The diversity of the generalist role of practice nurses has been well cited in the literature (Halcomb et al. 2005; Patterson et al. 2007; Phillips et al. 2009). Overall, the nurses were satisfied with the everyday diversity, describing the day as unpredictable and challenging. The participants had varying degrees of confidence in managing the diversity and flexibility demands of the rural generalist role and this could be related to the knowledge and skill preparedness of the practice nurses.

Most participants elicited personal satisfaction when they could groom their role. Grooming incorporated being able to mould their skills into their role taking into account the general practice needs. Nurses who described conducting nurse clinics for INR, vaccination, and Well Women’s health screening appreciated the support of the GP. The participants enjoyed initiating primary healthcare prevention and promotion opportunities with their clients. The professional education they had consequently gained since first taking on the practice nurse role had facilitated change, not only in the level of personal satisfaction and professional development, but also in their roles as many felt they had progressed with knowledge, skills and experiences to work in advanced roles. This included running nurse-led clinics, providing primary healthcare prevention and promotion opportunities, with influenza vaccination, INR and Well Women’s screening clinics. Studies conducted by Mills & Fitzgerald (2008) and Patterson et al. (2007) identified that shared care enhanced practice nurse autonomy and sense of professionalism.

The ability and scope for the participants to be autonomous in clinical decision making was linked to the participants feeling valued and respected. One nurse particularly felt frustrated that her role was a subservient handmaiden role and not even part of the team. However, the
nurses felt their professional autonomy was restricted, despite feeling competent and confident with the care they delivered, as they had to await for the GP to consult the patient in order for the practice to claim Medicare entitlements. This was previously identified by Willis et al. (2000). It is anticipated that from early 2012 there will be fewer practice nurse Medicare item numbers available, and the implications for nurse autonomy remains unclear as GPs will be predominantly subsidised with block funding for practice nurses (Medicare Australia 2012). There was no literature that evidenced the practice nurses’ stress and tension related to a changing role in line with the new practice nurse and chronic disease items numbers.

Cited barriers to learning by Meadley et al. (2004), were predominantly time off work, expense and family commitments. The nurses’ identified that more educational opportunities were needed to maintain competency. Educational issues identified in this cohort were found to be similar to a practice nurse educational needs study conducted by Meadley et al. (2004). One participant identified that a practice nurse mentor would have helped her transition into general practice, as she felt that mentorship had helped her as a postgraduate nurse in the hospital system. The NHHRC (2008, p. 326) identified that the culture of learning within the rural workforce is very important and states:

In order to train the future workforce, we need to embrace all available training sites and create a culture where teaching and learning are considered ‘core business’ of our health system. At the moment this is not possible because of the lack of infrastructure and ongoing educational support outside the traditional hospital setting, and to a lesser extent community setting (for example general practice and community health centres).

The future consideration of the development of these training centres identified by the NHHRC (2008, p. 327) is an integral part of the retention of experienced practice nurses.

**Theme 3: Being ‘good for business’ (making money)**

The third theme, being ‘good for business’ (making money) describes how the participants tried to maintain their professional integrity in order to deliver a high quality nursing service,
with financial efficiency. This first sub-theme, time is money, explores the stress participants often felt as they considered the impact of time restraints on nursing care. The participants explained how they needed to optimise the time they spent with clients, including accommodating emergency fit-ins within the nurses’ schedule, the time spent triaging and providing emergency care, and optimising the GP’s time and efficiency.

The second sub-theme, increasing efficiency with dedicated nursing space, identifies the need for nurse order and efficient working space. The participants needed to be supported with adequate nursing spaces in the practice infrastructure. The participants who shared spaces with other health professionals expressed resentment, as they felt they were a “devalued” member of the general practice. The most satisfied nurses had dedicated nursing spaces with their own equipment and resources for professional patient consultation, and often had a separate treatment room. Table 4.5 provides a map that describes the emergence of categories, sub-themes and the theme of being ‘good for business’ (making money).

Table 4.5: Mapping of categories, sub-themes and the theme ‘being ’good for business (making money)”

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-theme</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business model for money</td>
<td>Time is money</td>
<td>Being ‘good for business’ (making money)</td>
</tr>
<tr>
<td>Employment conditions</td>
<td></td>
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<tr>
<td>Monitoring nursing schedule</td>
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<tr>
<td>Opportunistic nursing care</td>
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<tr>
<td>Optimising GP time</td>
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<tr>
<td>Optimising patient time</td>
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<tr>
<td>Nurse time for education</td>
<td></td>
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<tr>
<td>Extra fit-ins/emergency care</td>
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<tr>
<td>Practice facilities and equipment</td>
<td>Increasing efficiency with</td>
<td></td>
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<tr>
<td>Creates own dedicated space</td>
<td>dedicated nursing space</td>
<td></td>
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<tr>
<td>Nursing tools/resources</td>
<td></td>
<td></td>
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<tr>
<td>Separate treatment room</td>
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**Time is money**

This sub-theme describes how the nurses’ need to make money influenced the way the participants conducted their role. The participants described a struggle in balancing the quality of their care to support both the medical service offered and the expectations of the business for nurses to generate an income.
The participants were well aware that they needed to deliver nursing services in a financially time-efficient manner for scheduled patients, opportunistic care and emergency fit-ins/triage. Compounded by the need to provide opportunistic care was a sense of duty to have a “nurse-friendly” schedule that did not keep clients waiting. One participant described how the patients did not like prolonged waiting periods (more than half an hour) for the nurses, this was thought by the participants to reduce patient satisfaction and have a negative impact on the “business”. The participants described how they felt that their time scheduling was “very restrictive”, particularly when there was little consideration for the nature and the complexity of the nurse service. Running behind schedule caused workload stress for the participants. All participants identified the way they used their time needed to be cost-effective. One participant felt she was very good for business efficiency:

people don’t mind waiting an hour or two for the doctor but they won’t wait that long, 
they don’t like waiting that long for the nurses (Vicki: p12, 387-389) 
this is a business where you need to push people through in a very humane, 
diplomatic and… caring way, so I think our job here... it’s a business and they need to make money from it (Vicki: p8, 239-244)

Most participants were dissatisfied with time restraints exacerbated by emergency patients (“fit-ins”) and the complexity of chronic disease management and education. Michelle described how she worked on ten minute appointments and usually felt

pushed for time... especially when you are trying to educate chronic diseases
(Michelle: p11, 348-352).

Michelle identified that the allocation of nurse time was problematic as all patients take different amounts of “coaching”; however, to remain time efficient, she referred clients for education to allied health and community health services nearby in the town. One participant identified that she found she enjoyed taking time to educate patients particularly in diabetic reviews, as well as the Medicare rebates and gap payments being very good for the practice income. The participants who worked more than half an hour away from the main town seldom described patient education in their roles, other than the fact there was little time allocated to this due to extra unscheduled, emergency patients.
Occasions for nurse clinics were described by two participants; however, the GP also needed to consult each client encounter to maximise Medicare rebates. One participant (Michelle) described how she had an INR clinic each morning, and a Fluvax (influenza immunisation) clinic before winter, and the doctor intermittently saw the patients in the clinic session in order to claim Medicare item numbers. The other participant (Libby), had a special interest in diabetes and conducted her own clinics. As part of the chronic disease care plan review process, however, she later discussed how in her role (as both practice manager and practice nurse) she needed to encourage client compliance to attend regularly, as there was financial pressure from the practice business:

> it’s not just about patients care, it’s also that it’s running a business and we have to fund to pay for wages, overheads and other projects that we want to do

(Libby: p13, 428-30)

These examples identify that the clinics are not nurse-led/driven entirely, as the GP needed to review the client for the purpose of meeting funding requirements from Medicare.

**Increasing efficiency with dedicated nursing space**

This second sub-theme identified that nurses enjoyed having ownership of a dedicated professional nurse space. The participants were very proud of the way they had designed, or assisted in the set-up of equipment in this area. However, not all participants had been provided with separate nurse-dedicated facilities. The participants were most satisfied when they had their own desk and computers and a treatment room set up with a treatment bed and appropriate stock such as wound dressings, emergency care such as oxygen, spirometer and ECG machine. The participants used this space for emergency resuscitation, IV hydration, procedures and chemotherapy, and a separate private consulting room for private care consults such as care planning. The participants all had different tools readily available they used for patient education such as posters and disease models that supported their role. They described how they developed a functional working environment that they felt flowed well and supported patients’ dignity. The participants were very proud of this space and felt “professional”. These facilities assisted the participants to deal with emergency patients as part of their routine role and described how they needed to have appropriate treatment facilities to provide optimal care. Most disappointed, one participant (Amelia) had her desk added to the side of the main corridor, and worked where needed, as the GPs “buzzed her” to
their rooms or to a treatment room to attend a particular task. This participant described how she felt about the lack of dedicated nursing space:

*Quite often um we are the last to be considered for financial things like workspace, um equipment and it's just really frustrating to feel like you're not even part of the team... they have factored in the cost of the medical students room and given them more facilities... it hurts because it makes you feel like the work you are doing isn't appreciated* (Amelia: p9, 279-281)

One participant identified that their workspace was shared for other purposes:

*it’s a little tiny house and he has his room and I have mine, but mine is also a room... I’ve set up a bed for Pap smears and people get checked in there for ECG... and also our tea room in there with the little sink and a little fridge... so that’s the little room used for so many things...* (Mandy: p12, 398-411)

Another participant was annoyed when she needed to share the nursing space:

*this is my little interview room, office area. I share it with the (MAHS) dietician when she comes, and more to the point she takes it off me and I get shunted into the treatment room... I like my own little space, this is my space and I enjoy having everything where I want it and when someone else is here I have to clear it all away and make it look neat... and that annoys me need to look at it, it's my space get out* (Christine: p10, 303-307)

Two participants’ workspaces appeared well set up for clinical care. The spaces were described as “handy” and “easy” with equipment “well labelled”.

In relation to needing to be cost-effective with materials and equipment, Michelle identified that she could do a dressing, but had to be mindful of the time and expense associated with this procedure and needed to "justify" stores to the practice manager as:

*they (the stores) do not come out of the ether like in the hospital*

(Michelle: p12, 389-390)

Currently there is no Medicare funding considerations for practice nurse workplace setup, that is, structural facilities to accommodate the practice nurse by Medicare. All participants
were satisfied that they had easy, direct access to a nurse-dedicated computer. Computer access for nurses will be pivotal in delivering efficient care, especially when the proposed ehealth system is introduced in mid-2012. As part of the PIP payments, funding will be allowed for computerised equipment through Medicare rebates and gap payment services (HMA 2005). It is important to recall that most rural GPs have worked for many years without a nurse working with them, so providing expensive infrastructure to accommodate nurses may not have been fully considered. All practice nurses clearly described that having their own professional space was really important and when this was compromised they were dissatisfied.

A study conducted by Weymouth et al. (2007) investigated remote area nurses who described being treated as “second class citizens” by management, particularly when “inadequate infrastructure and poor work environment created a perception amongst remote area nurses they were not considered important enough, for adequate services to be provided” (Weymouth et al. 2007, p. 13). The nurses in this study evidence that it is important that rural practice nurses need to have the facilities to deal with the diverse range of client care needs in order to maintain professional standards of nursing care in general practice.

**Discussion of Theme 3: Being ‘good for business’ (making money)**

The participants identified the general practice business needed to make money. The business income was primarily generated from Medicare rebates and gap payments for medical and nursing services. The need to make money influenced the way the participants conducted their role. The participants described a struggle in balancing the quality of their care to support both the medical service offered and the expectations for nurses to generate an income for the business. The need for adequate nurse time with clients was identified by Phillips et al. (2007) and McDonald et al. (2007).

Some participants did not have schedules that allowed for emergency fit-ins/triage. It was important for nurses to provide opportunistic care and have a “nurse-friendly” schedule, as they do not like to keep clients waiting. Consumer expectations of practice nurses studied by Cheek et al. (2002) was that nurses had the time and caring characteristics which enabled them to support GPs.
The participants discussed how they supported the GP by initially triaging patients that arrived unexpectedly and providing emergency care. The participants described their clients as “stoic”, “proud” and the “private” nature of the community (tough farmers and manual labourers), and claimed that the problems of long distances and waiting times in local emergency departments, or there being no doctor on duty were reasons why emergency care was sought at their practice. Practice nurse triage education programs have been implemented by a collaboration between the AGPN & GP Access (2013) and is available online; and three sessions are now available for rural nurses to access.

Adequate nurse-dedicated facilities was important for the participants to deal with emergency patients as part of their routine role, and they described how they needed to have appropriate treatment facilities to cope with these clients in addition to a private consultation space. One participant without any dedicated nursing space felt “frustrated”, “not part of the team”, and “not appreciated”. The need for nurse-dedicated space was found to be important in nurse satisfaction in a study by Weymouth et al. (2007) where poor infrastructure made remote area nurses feel like “second class citizens”.

**Theme four: Mastering the art of living**

The fourth theme, mastering the art of living, links to the satisfaction of the participants attaining a “life-work balance”. The theme is divided into two sub-themes, meeting family commitments and being part of the rural community. The first sub-theme, meeting family commitments, emerged from nearly all of the participants discussing that they had an obligation to care for children living at home. Participants were satisfied as practice nursing was a perfect job for fitting in with family commitments and time to enjoy the rural coastal lifestyle with friends. The enjoyable aspects were the safe family environment, being social with lots of friends, being able to volunteer in their community, the convenience of low travel distances/time to work, and contentment with flexible family-friendly work hours.

The second sub-theme, being part of the rural community, identified both the personal and professional connectivity with the community. Most of the participants had previously
worked in a rural area and/or had a childhood in a rural area, feeling that they had always belonged. The participants from urban and regional areas described that it was important to develop professional relationships, especially when they first came to the general practice. The participants mostly described how they needed to feel acceptance and trust in order to belong to the community in which they work. However, this was not the case for one participant who moved out of the rural community in which she worked with her GP husband, as she did not enjoy the loss of anonymity. She felt there was never enough time off with their family. Table 4.6 provides a map that describes the emergence of categories, sub-themes and the theme of mastering the art of living.

Table 4.6: Mapping of categories, sub-themes and the theme ‘mastering the art of living’

<table>
<thead>
<tr>
<th>Categories</th>
<th>Sub-theme</th>
<th>Theme</th>
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<tbody>
<tr>
<td>Lifestyle</td>
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<tr>
<td>Rural living</td>
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<tr>
<td>Family commitments</td>
<td>Meeting family commitments</td>
<td>Mastering the art of living</td>
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<tr>
<td>Working hours</td>
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<tr>
<td>Travel</td>
<td></td>
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<tr>
<td>Rural community work</td>
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<tr>
<td>Upbringing of nurse</td>
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<tr>
<td>Rapport with community</td>
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<tr>
<td></td>
<td>Being part of the rural community</td>
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Meeting family commitments
The first sub-theme, meeting family commitments, describes how the participants enjoyed life-work balance that practice nursing provided with family-friendly hours. With no after-hours shift-work and weekend work, participants had time for activities such as collecting children from school and supporting children’s sport out of school hours. The working hours of practice nursing also enhanced the participants’ social life with family and friends, and importantly spending Christmas day with family.

*Biggest drawcard... quality of life with my family... it is more about my family and I really love that. I don’t think I’d ever, would ever, would have found that fulfilment just in nursing... but now in general practice* (Amelia: p7, 214-217)

Being part of the rural community
The second sub-theme, being part of the rural community, describes how through practice nursing the participants were provided the opportunity for participation in community events such as fundraising for the Cancer Council, chatting and offering health advice to clients at the local supermarket and supporting health in their children’s schools. The participants enjoyed community recognition and status as a practice nurse, as they felt the community had great respect for the importance of the general practice surgery. Four of the seven participants came from a rural upbringing or had nursed and lived in rural communities prior to practice nursing, and were connected to, and integrated within, the community through long term relationships with family, friends, schools and small business operators. The participants felt that they were trusted and respected by their community.

*I grew up around here... I think we will always be... in a similar rural setting*
(Amelia: p5, 164-165)

The literature identified that those who are brought up in a rural area are more likely to stay and work in a rural area (Hays et al. 1997; Hegney et al. 2002b; Harding 2006). The rural lifestyle emerged as a way of life for the practice nurse, and has been related to the attractions of rural community living and the ability to share their out of hours commitments with loved ones (family, partners and friends) who resided in the same community.

Five of the six participants had children and preferred to bring their children up in a rural area because of the rural lifestyle. The rural lifestyle was described as safe, friendly, secure as members of the community look out for each other, and healthy as there were lots of sporting opportunities for their children. One participant chose to send her children to a metropolitan boarding school for greater secondary education opportunities, whilst all the other participants with school-aged children chose to use education facilities in the area. Two participants cited they chose to live in this particular rural area due to their partners work commitments.

*realistically, because I don’t want to go back to the hospital system. I don’t want to work weekends. I don’t want to work night shift. I’ve had enough of all that... there has been occasions where Christmas morning, you know my husband has had to hold back the children from opening up presents... so I don’t want to do that*
The strong social networks, sense of belonging to a community, bringing up family and living the “rural lifestyle” were identified as main characteristics of rural life for rural nurses (Hegney et al. 2002b). Overall, this ability to achieve a high quality lifestyle with their family provided the greatest “drawcard” in this study and has been proven to provide the greatest satisfaction to the participants.

Michelle enjoyed the convenience of practice nursing in terms of flexible work hours and workmates that allowed her to care for her children, even when they were sick:

*Flexibility, the hours,... really fantastic workmates, so that really helps... and you know its never a day where you go home and think I’ll never go back there (to the hospital)... I think I could be there until retirement age...* (Michelle: p9, 291-295)

Five of the seven participants identified the convenience of living near the general practice (less than ten minutes). For two participants who lived 30-45 minutes away from the general practice, travelling was seen to be part of the job. Mandy preferred to work closer to home whilst another participant (Libby), deliberately wanted to maintain anonymity by distance. The participant (Libby), married to a GP, preferred the distance from the practice as this reduced the after-hours disruption to family time.

**Discussion of Theme 4: Mastering the art of living**

The participants were contented with achieving a life-work balance. The practice nurse hours were convenient to meet family obligations. The role was seen to be a “pleasure” and a “privilege” as the participants felt their work contributed to their community. Most of the participants had a rural upbringing from childhood, or had worked and lived in rural communities prior to practice nursing, and were connected to, and integrated within, the community through their relationships with family, friends, schools and small business operators. The rural community sense of acceptance and belonging has identified as important in a study of rural nurses and was related to them residing in their communities over long periods of time (Hegney et al. 2002b).
The literature identified that healthcare workers, both nurses (Hegney et al. 2002b) and pharmacists (Harding et al. 2006), who are brought up in a rural area are more likely to stay and work in a rural area. Nearly all of the participants had children, and those who did cited working around family commitments was the greatest attraction to rural practice nursing. Unlike rural nurses studied by Hegney et al. (2002b), most rural practice nurses enjoyed being known and recognised by community citizens. It was important to the participants to establish a relationship with their rural clients, and once established, they clearly enjoyed the professional recognition and rapport developed from the practice nurse role. The more experienced participants (greater than ten years practice nursing), identified that clearly defined professional boundaries were necessary as professionally, it was important not to become personal friends with patients. The need for clear professional boundaries has been described in a recruitment and orientation resource for practice nurses by the AGPN (2006).

Conclusion to results and discussion chapter

The relationship between the social aspects and rural practice nurse role and nurse satisfaction
The research findings indicate that the participants were very satisfied with the social aspects of the rural lifestyle, working close to home and the family-friendly hours. The participants were also motivated by, and satisfied with, the trust and professional recognition they had elicited from their community. These findings can be related to the rural practice nurses residing in rural communities over long periods of time. This complete emersion and regular contact through the general practice setting enabled the participants to understand the unique cultural identity of their client base and address their clients’ specific health needs appropriately across the lifespan.

The relationships between the intrinsic and extrinsic professional aspects and rural practice nurse role and satisfaction
There are some significant concerns which may impact on the retention of these participants as they were not always satisfied with issues relating to their scope of practice. This
dissatisfaction related to the intrinsic and extrinsic restrictions associated with the conduct of a private business: role autonomy, remuneration, education, time management and nurse-dedicated infrastructure. The nurses were not necessarily professionally prepared for the evolving practice nurse role in order to stay within their scope of practice and perform to meet the expectation of the general practice.

Intrinsic factors including the impact of job satisfaction from interpersonal relationships with clients are overall very satisfying in this cohort, as they had built strong levels of trust and acceptance from their clients which enhanced the practice nurses’ satisfaction in the therapeutic relationship with their clients. There were varying degrees of practice nurse satisfaction in the collaboration with their GP; this was related to the evidence of GP acceptance and trust when the practice nurses were given the opportunity to use prior knowledge and skills autonomously. The practice nurses also sought support for greater educational opportunity to build upon these skills, particularly for nurses who recognised their “specialties”, such as midwifery and emergency care. The practice nurse satisfaction was also linked to the nurse time schedules, and there was frustration expressed as the nurse was expected to conform to a schedule that optimised Medicare item numbers without necessarily accommodating the complexity of client needs and emergency fit-ins which may be complex “moderate emergencies”. The practice nurses’ desire for professional acceptance was found to be related to practice facilities and equipment, and the ability to maintain their patients’ dignity and privacy. When the nurses’ own professional space was compromised the nurse was dissatisfied. Whilst all of these concerns are related to the intrinsic issues of the practice, they can also be related to funding mechanisms stemming from the GP business model, predominantly funded by Medicare.

Extrinsic factors that were not controlled by the practice nurse including remuneration and the culture of the GP could be related to the business financial model and practice nurse funding arrangements. When it came to remuneration, evidence suggests practice nurses believed their skills and years of expertise should be valued and recognised in their pay. It was interesting to note that when it came to actual rate of pay there was a compromise, with the majority of participants accepting that the pay rate was not an important consideration compared to the quality of life offered through the convenience of family-friendly hours including no shift work. The area of greatest dissatisfaction was limited study leave to pursue
educational opportunities to keep their education and clinical skills in line with the changing role expectations. They identified they needed to keep nursing tasks current to maximise emerging Medicare incentive payments to general practice business. A GP who had been recruited from overseas to work in the area of need was problematic for the participants. The participants felt they were not culturally prepared for the communication gaps, as the GP had difficulty in expressing cohesive information between the nurse and rural clients. The participants enjoyed being familiar with their own community and services, as they had resided in the same rural community over a long period of time, which especially complemented the services of the overseas trained GP.

The relationship between rural practice nurse satisfaction and why rural practice nurses remain in the Australian workforce

This chapter has demonstrated the results of a thematic analysis from interviews with seven practice nurses working in rural general practice. There were four main themes that emerged relating to rural practice nurse retention, in this small qualitative study: striving for professional recognition, grooming nursing services to meet needs, being ‘good for business’ (making money), and mastering the art of living. Overall, the participants are satisfied with their practice nurse roles within their rural communities, enjoying the lifestyle and family-friendly hours. Once a collaborative working relationship with the GP and clients was established, participants generally felt satisfied. They mostly enjoyed the diversity in their client ages and each working day. They see the role as an evolving one that requires them to constantly up-skill, and appreciate any workplace and local financial support and convenience for education opportunities. It was important for the participants to have adequate workspace and equipment dedicated to their role.

The participants described disappointment in accessing suitable education that was timely, convenient and cost-effective and in work time. Generally the participants were uncomfortable seeking the GP’s approval for educational courses, based on relevance to item numbers, within “budget”, and approval for time away from the practice or suitable for after hours in family time. The participants were frustrated when they had heavy workloads exacerbated by time restraints and emergency patients where they felt they were not sufficiently competent. The participants were most disappointed where they felt remuneration was inadequate and practice infrastructure did not support their role.
The participants were most dissatisfied where they discussed financial hardship due to cost of courses and low remuneration. They were disappointed they had unclear leave entitlements. The participants did not like task-orientated workloads and feeling unprepared for emergency clients when not suitably trained. The participants were concerned about medico-legal ambiguity, particularly regarding patient privacy and home visits.

This results and discussions chapter has explored the findings of this study which identified the factors influencing the satisfaction of rural practice nurses. These factors are important for future workforce planning for the retention of rural practice nurses. The next chapter concludes this thesis and will present a summary of the study, the limitations of this study and the recommendations based on the study’s findings. Significantly, the findings provide evidence for strategies to improve the retention of rural practice nurses.
5. Conclusion

General practice nurses provide support to rural GPs working in communities where there are high health care needs and a GP workforce shortage (AIHW 2008). Since the implementation of the NiGP Initiative in 2002 (DoHA 2002), there has been a strong focus from the Australian Department of Health and Ageing through the National Primary Health Care Strategy driving primary healthcare services to improve health access to rural communities (NHHRC 2008).

The practice nurse workforce offers valuable and diverse generalist roles that support GPs, particularly in the provision of primary healthcare chronic disease prevention and health promotion. A literature review exploring social and professional issues related to rural nurses and practice nurses identified that whilst there has been significant growth in practice nurse numbers, the support needs of practice nurses are not being met, predominantly: inadequate access to education and training, a lack of formal career pathway, a need for adequate infrastructure and low remuneration. The 2009 AGPN National Practice Nurse Workforce Survey reported there were 8,914 practice nurses (an increase of 15.3% since 2007), working in an estimated 56.9% of general practices throughout Australia (AGPN 2009). Practice nurse demographics are significant to future planning around the retention of rural practice nurses and have identified an ageing workforce that now has 79.7% of nurses aged over 40 years, with 38% of nurses aged over 50 years (AGPN 2009).

It is important to explore the needs of the rural practice nurse so nurses are retained to support critical GP workforce shortages in rural areas with populations with high health needs. This study explores the social and professional issues that effect total rural practice nurse retention. A qualitative methodology incorporating semi-structured interviews was conducted with rural practice nurses in 2008 and 2009. Data saturation was reached after seven interviews. Following thematic analysis of the interview data, four key themes were identified: striving for professional recognition, grooming the role to meet practice needs, being ‘good for business’ (making money), and mastering the art of living. The major
findings of this study, demonstrated in this thesis, provide an evidence-based understanding of the rural practice nurse role. The findings of this study provide significant background information for future primary healthcare considerations, especially for the rural practice nurse workforce.

Summary of Literature Review
Following an extensive search of books, journals and government websites, information related to rural nurses, rural health professionals, and practice nurses was gleaned. The literature identified that many of the rural health workforce roles are shared amongst health professionals including nurses, GPs and pharmacists. The findings of the literature review is arranged into four key themes: nursing in the rural context, the integration of nursing into general practice in Australia, practice competency, and practice nurse support.

The first theme, nursing in the rural context, describes the literature related to health workers in the rural context. Rurality was found to affect the role of nurses and health workers as there are fewer services, greater distances to travel to specialist and allied healthcare services, less choice in available services and a smaller healthcare workforce (Bourke et al. 2004). Whilst rural nurses enjoy knowing patients and their families, and enjoying the strong social network of family and friends, the main reason for rural nurses leaving loss of anonymity (Hegney et al. 2002a). Insufficient access to training and education was seen to contribute significantly to job dissatisfaction in rural GPs (Hays et al. 2007), rural pharmacists (Harding et al. 2006) and rural nurses (Hegney et al. 2002c).

The second theme, the integration of practice nursing in Australia, identifies literature related to the consequences of the recruitment of new practice nurses in 2002. This recruitment is in response to the NiGP Initiative with support from the Australian Department of Health and Ageing (DoHA 2006), as a strategy to address the general healthcare workforce shortages, particularly in rural underserviced areas. However, the practice nurse workforce is ageing (AGPN 2007), and this has an implication for retention of many rural practice nurses, particularly as they seek retirement in an area of health workforce shortage. Greater team communication is identified as a key component for GP-nurse relationships to be collaborative (Mills & Fitzgerald 2008; Halcomb et al. 2007). Time restrictions on practice nurses were found to negatively impact on the nurse-patient relationship and quality of
nursing care (McDonald et al. 2007). It was important for practice nurses to have time to elicit a trust relationship and additional health related information for assessing patient care needs (Phillips et al. 2007).

The third theme, practice competency, identifies challenges for practice nurses, insufficient role preparedness (Cross 2006), inadequate access to professional development and the lack of a structured career pathway (Halcomb et al. 2005). For practice nurses the barriers for education were predominantly personal: time, work commitments, family commitments, and financial problems (Pascoe et al. 2007; Meadley et al. 2004). Professional development emerged as an issue in the business and time savvy environment, where it was found that practice nurses have little opportunity and/or funding to attend to professional development needs (Pascoe et al. 2007).

The fourth and final theme, practice nurse support, describes the current funding mechanisms in literature for practice nurses. The remuneration of practice nurses in 2008 was low compared to hospital-based nurses (APNA 2008). There are no financial incentives given to practice nurses practising in a rural area, unlike incentives provided to rural GPs (NRHA 2002). Medicare funding to support the business model is not conducive to autonomous nursing, as for each single client interaction to be profitable the GP must either intercept or supervise a service rendered (Willis et al. 2000). The current Medicare funding for general practice encourages high flow of patients, with no reflection on the quality of nursing care delivered (NSW Health 2005). There is professional support for rural practice nurses through scholarships opportunities and membership to professional organisations, particularly the Australian Practice Nurses Association (APNA 2007).

Overall there is scant literature related to the rural practice nurse workforce, yet the retention of this workforce was found to be essential to support the high healthcare needs of rural communities where healthcare workforce shortage exist, especially with the GP workforce.
Purpose of Research

The broad aim of the study was to investigate the rural practice nurse workforce. The three objectives of the study were: to investigate the reasons why rural practice nurses remain in the Australian workforce, to identify the social aspects that effect rural practice nurse retention, and to identify professional aspects that effect rural practice nurse retention.

Method

This small exploratory qualitative research study investigated rural practice nurses on the New South Wales south coast with one to one semi-structured interviews. The interviews were transcribed verbatim. An investigative approach was undertaken as the research identified that little was known of the topic and a thematic content analysis of the data were conducted. Thematic analysis of the data were entered using the computerised NVivo 7 software to group similar categories into sub-themes and then into four key themes. Data saturation was attained after seven interviews, as the same sorts of issues were replicated in the nurse responses. Using the transcription data, the themes were analysed and explored in relation to both social and professional satisfaction of the participants.

Results and Discussion

The findings of this qualitative study identify four key themes: the pursuit for professional recognition, grooming nursing services to meet practice needs, being ‘good for business’ (making money), and mastering the art of living. Demographically, the participants were comparative to the National Practice Nurse Workforce Survey across Australia in 2007, which was conducted at the time of this study, although it is difficult to make strong comparisons due to the small number of participants in the current study.

The first theme, striving for professional recognition, evidences the professional journey that participants describe from first starting practice nursing to the time of the interview. The
professional challenges the participants needed to overcome were to accept and adapt to the diversity of the general practice: the culture and attitudes of the GP, to gain the respect and trust of clients in the community and the GP, and overcome the stress and tensions associated with developing a new identity as a practice nurse whilst feeling isolated from their previous work setting. With unclear role descriptions and limited opportunity to network with other practice nurses, the participants developed their new role to “fit in” with the needs of the practice. The participants also described the need to feel valued as a health professional within the general practice team. Most participants felt they were inadequately renumerated when compared to the experience of colleagues in other nursing settings.

The second theme, grooming nursing services to meet practice needs, describes the anxiety the participants felt as a novice practice nurse due to the unfamiliarity of the generalist role. Over time, there was evidence of professional growth in the participants’ role evolving with greater skills and education, most participants described how they individualised, “groomed”, adapted and moulded their roles to suit the practice needs. For most, the rural practice nurse role required greater clinical decision making in “mini emergency department” treatment rooms and providing some nurse clinics, including Well Women’s health screening.

The majority of participants felt they needed to extend their knowledge and skills to perform tasks competently. Education was needed to meet role expectations of the general practice management, which kept changing due to MBS financial incentives from Medicare. The participants expressed difficulties in accessing adequate education and training due to lack of GP support, the cost, the distance, and time away from family. The participants’ need for a diverse range of nursing skills, particularly emergency care, can be related to a rural location as many of the practice nurses felt obliged to undertake tasks as there were few localised support services within the local community, often at least 30 minutes from the main town health support services.

The third theme, being ‘good for business’ (making money), describes how the participants try to maintain their professional integrity in order to deliver a high quality nursing service, with financial efficiency. The participants felt tension in balancing the quality of their care to support both the medical service offered and the expectations for nurses to generate an income for the business.
Some participants did not have schedules that allowed for emergency fit-ins/triage. The participants felt it was important to them for nurses to provide opportunistic care, and have a “nurse-friendly” schedule, as they did not like to keeping clients waiting for their services. Adequate nurse-dedicated facilities were important for the professional role as without them one nurse felt “frustrated”, “not part of the team”, and “not appreciated”. The need for nurse-dedicated space was found to be important in participant satisfaction levels.

The fourth theme, mastering the art of living, links to the satisfaction of the participants attaining a life-work balance. Most participants had children living at home and described satisfaction in meeting family commitments while enjoying the rural coastal lifestyle. The majority of the participants had previously worked in a rural area and/or had a childhood in a rural area, feeling that they had always belonged. Participants from urban and regional areas described how it was important to develop professional relationships to be accepted and trusted by the community in which they work. Finally participants enjoyed the convenience of family-friendly hours believing it added to their quality of life. Most participants thought the fulfilment of a life-work balance compensated for their lower wages.

Together these four key themes provide an insight into the social and professional life journey the participants have travelled since first practice nursing. The participants’ satisfaction has been expressed in terms of their sense of accomplishment in meeting the needs of the role, feeling confident and competent in the role, feeling professionally valued and respected and having the personal fulfilment of emotional wellbeing in achieving a life-work balance.

**Strengths and limitations of the research**

**Strengths**

This is the first Australian study to explore the rural practice nurse role – The literature review identifies there are no exploratory studies conducted on Australian rural practice nurses, and the results of this study provides insight into the social and professional issues associated with the rural practice nurse role and is a starting point for future research.
The methodology used in this study facilitated exploration of the rural practice nurse role. The questionnaire proved a simple and useful tool that incorporated prompt questions to elicit depth as needed, and facilitated a conversational style questioning. The use of an easy to use and reliable digital voice recorder produced high quality recordings. The professional assistance of a transcriber and professional NVivo 7 data analysis support provided strong foundations for succinct data analysis in this project.

Reliability and consistency in results – The consistency of data has been achieved through close examination and verification with supervisors throughout. The use of NVivo 7 software was valuable in analysis, during which there was an examination and discussion of the coding of the raw data into categories, data reduction and the grouping of relevant data into sub-themes and themes with a systematic and critical analysis within a thematic analysis.

The project has attracted interest in health policy stakeholders – The author has presented at three national conferences attended by key health policy stakeholders.

**Limitations**

The rural practice nurses participants were recruited from a rural location with a RRMA allocation of four (4) (PHCRIS 2009). Geographically, the findings from this small qualitative study cannot be deemed representative of Australia in its entirety, due to the geography of the country and the diversity of the population. Since the time of data collection, there has been a change to the classification of rural areas; the category for this research area is now referred to as Remoteness Area 3 (RA03).

The use of semi-structured interviewing provided both closed and open questions. However, the problem with exploring the reactions and thoughts of individuals from interviews with qualitative research is that the generalisability is reduced (Patton 2002). The participants’ responses captured what they felt were problems and considerations at the time of the interview.

Participant consent did not identify if the respondent was an enrolled nurse or a registered nurse. This question would have been helpful to add depth to this research.
Implications

Policy
Practice nurses should be involved in policy development within both local and government organisations to formulate a career path that can be adapted to a range of primary healthcare settings. This should consider the inclusion of a transparent remuneration structure with conditions and entitlements, education support and indemnity insurance.

Practice nurses are great networkers and provide linkage within their community. Future reform in primary healthcare should consider nurses as facilitators of close long term community connections, where they can provide leadership in health initiatives to improve health outcomes, particularly in rural areas. Greater support is needed to ensure both practice nurses and their clients’ healthcare needs are understood.

Primary healthcare funding mechanisms should recognise and support education and training for rural practice nurses to extend their services to support keeping clients out of emergency departments.

Education
Rural practice nurses are not necessarily prepared for their role. There is a period of role adaptation where they learn the culture of the business of general practice and the diverse needs of the general practice. For nurses working with doctors from culturally diverse backgrounds with English as a second language, localised training opportunities should provide communication strategies to assist nurse in acting as “the interpreter”.

Greater support is needed for sustained practice nurse education schemes for long term training, particularly in emergency care. It is vital to broaden skills and knowledge to prepare rural nurses for the generalist practice role, and for advanced roles that expand primary healthcare health promotion and prevention programs across the community and within nurse clinics in the primary care setting.
Research
Education, teaching and mentoring should be further investigated as part of the advanced nurse role, to identify if this improves educational opportunities in rural and remote general practice nursing. One nurse identified that a practice nurse mentor would have helped her transition into general practice, as she felt that mentorship had helped her as a postgraduate nurse in the hospital system. An advanced nurse mentor model could also promote and develop more advanced nurse practice and nurse clinics in general practice.

Management
Nursing roles should remain flexible and provide for greater expansion to incorporate mentoring and support for student nurses, new practice nurses, and practice nurses seeking to up-skill. This will require greater support from experienced practice nurses, GPs, Medicare Local, and affiliated organisations. The general practice business needs to support practice nurses with flexible family-friendly hours in their work arrangements. Part-time working arrangements enable practice nurses to cover each other’s sick leave and holidays within the practice.

Infrastructure dedicated specifically for nurses needs to be effective and appropriate to the setting. Where there is a high demand for emergency services in the practice, a dedicated treatment area and private consulting areas are vital for nurse efficiency and patient dignity. There is a need for the recognition of nurse time and the business balance. The nurse appointment schedule needs to recognise the time needed for quality care in booked appointments, triage and emergency care, whilst minimises patient waiting time.

Nursing practice
The expansion of the practice nurse role in primary healthcare is now becoming a major focus for change within Australian healthcare policy. There must be a balance between cost and developing the strength of rural practice nurses working in the primary healthcare sector, to address the worsening health status of rural Australians. Within the literature there is no evidence of the pivotal role rural practice nurses play in emergency management, yet in this study it is found to be a major component of the rural practice nurse role. In episodic care of clients with minor illness and injury, immunisation, wound care and long term chronic disease, health prevention and promotion was a limited part of their role, as described by
participants. However, if the Australian Government is committed to retaining a rural practice nurse workforce, there needs to be further investigation into a sustainable system devised to support the education and training needs of rural practice nurses.

It is hoped that in the future there will be a greater business partnerships between practice nurses and GPs. The emergence of nurse-led clinics for chronic disease management is a welcomed direction into future healthcare delivery, particularly for rural areas to assist in healthcare workforce shortages and communities with a poorer health status. It is hoped that this will see the progression of a viable career option for practice nurses and provide greater clarity in differentiated roles from novice to extended role through to advanced practice nurse roles, reflecting appropriate transparency and remuneration awarded at each level.

Current practice incentive (PIP) payments designed to encourage “general practices and Aboriginal Medical Services (AMS) in rural and remote areas to employ practice nurses and/or Aboriginal health workers” (Medicare Australia 2009) do not mandate practice nurse education and training. With the support of Australian Government agencies and professional nursing bodies such as APNA and the ANF, clinical governance could be integrated in the PIP scheme (Medicare Australia 2009) where part of the practice nurse funding must go towards educational opportunities for the practice nurse/s. Transition in 2010 to nationalised nurse registration through the Australian Health Practitioner Regulation Agency (AHPRA) has seen integration of national nurse registration with mandatory minimum continuing education requirements. However, as practice nurses are renumerated less than nurses working the hospital context, there is limited funded CPD support and self-funding mechanisms.

In January 2012, changes to the way practice nurse incentive payment is delivered to support GPs for the employment of practice nurses came into effect, ending the majority of practice nurse Medicare item numbers. The Practice Nurse Incentive Program (PNIP) block funding arrangement provides for a bulk incentive payment to practices based on the number of GPs employed, the standardised whole patient equivalent load, the number of practice nurses employed and a rural loading of up to 50% based on the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) (Medicare Australia 2012). With the introduction of this funding mechanism, six practice nurse items have been reduced to two.
items for nurse support of a client on a chronic care plan arrangement and to support the health of Aboriginal and Torres Strait Islander (ATSI) clients with health checks. There is an expectation from Medicare Australia that this will lead to increased practice nurse autonomy, particularly for the development of nurse support and nurse clinics for patients with chronic disease (Medicare Australia 2012).

Future
Consideration should be given to the feasibility of a practice nurse national satisfaction survey – incorporating practice nurses, GPs and clients – with its primary objective to identify perceptions of the future for the practice nurse role, and determine how practice nurses are best placed in primary healthcare in general practice. With further research, clear evidence-based government guidelines on the role of the practice nurse and how they can best meet expectations will provide the foundations for a progressive career structure, remuneration structure (such as a primary healthcare nurse award), and a framework for clinical governance and competence that meet the expectations of the role, particularly in rural communities where there are fewer health services. Parker et al. (2009) identified that national training standards and a process of accreditation for nurses is necessary to provide a quality education and career pathway for a sustainable primary care workforce.

There is an increasing base of evidence to demonstrate that practice nurses have provided benefits to general practice, both in terms of relieving GP workforce pressure and patient outcomes, following an evaluation of the Nursing in General Practice Program (HMA 2005). As a result of employing a practice nurse, the number of patients a GP can see in a day has increased by 16 (AGPN 2005). Evaluation of the NiGP also found improved throughput of patients in general practices employing a nurse: patient waiting times are reduced, GPs have more time to spend with patients, GPs have the opportunity to liaise more effectively with other health professionals about their patients. However, whilst the program has raised the profile of practice nurses, the expectations of patients are that practice nurses will have a broad range of skills to deliver quality care, particularly with chronic disease management and health promotion (HMA 2005). Therefore, practice nurses should receive specific education and funding to continue to contribute to the quality, accessibility and affordability of primary healthcare into the future,
Final Summary

Until the NiGP initiative in 2002 there was relatively little that had been done to encourage nurses to work in general practice to assist GPs particularly in rural areas where there are significant workforce shortages. This is the first Australian study to identify factors that are important to and influence the length of time rural practice nurses are likely to stay in general practice in their communities. The results of this research provide insight into the rural practice setting from practice nurses themselves.

Overwhelming evidence identifies that professional factors are likely to determine the length of time a nurse will stay in the general practice context. The three key workforce problems for rural practice nurses follow.

Firstly, the difficulty of providing emergency care related to working within the rural context with smaller communities and locations distant from the main town centre where emergency department support exists. In the absence of professional support for practice nurse education, financial support for more practice nurses and time poor scheduling that reduces nurse quality care, and insufficient remuneration, will have a negative effect on nurse retention. Additionally, it is important to sustain the very attractions of the rural general practice setting, to accomplish a life-work balance, and quality of life with their families and the community.

Secondly, currently there are some rural education scholarship opportunities available; however, education needs to be sustained in the long term to encourage movement into advanced care roles. Education opportunities also need to be appropriate to the locality and suitably timed. Unlike rural GPs, there are no rural retention grants that would support adequate remuneration incorporating education, and this should be considered to improve the attraction to stay longer in general practice.

Thirdly, there needs to be a long term solution – a strategic plan for rural nurses that minimises the onset of triggers that may lead to practice nurses leaving prematurely; interventions must be groomed to promoting practice nurse satisfaction. A broad strategic solution incorporating several measures is required, including:
• Greater funding support for rural nurses to facilitate a reasonable quality of care with appropriate time allocation, particularly in primary healthcare patient education as the rural communities have a reduced health status and require access to emergency care, particularly as there are fewer support services.

• Develop an employment structure that provides appropriate remuneration for nurses in rural areas incorporating study leave, greater access for CPD funding support, professional indemnity insurance and greater employee transparency in remuneration records through pay slips to evidence hours paid, pay rates, annual leave owing, and sick leave.

• Support factors that engage practice nurse services, including support by administration staff in time scheduling of nurse services, and designated nurse facilities such as treatment rooms to facilitate efficient emergency care and a private consulting room, information technologies.

This research project identifies challenges for the development of a strategy to retain rural nurses in general practice, which takes into account the nature and complexities of the diverse generalist role. There is a great need to provide professional support for nurse knowledge and skills, nurse time and remuneration that reflects the professional responsibilities of their role. The introduction of such measures would not only retain the current rural practice nurse workforce whose greatest satisfaction is the life-work balance and rural lifestyle, but would also attract prospective nurses into the rural health workforce.
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Appendix 1

Faculty of Health and Behavioural Sciences
School of Nursing, Midwifery and Indigenous Health

The Retention of Rural Practice Nurses

Your invitation to participate in a study of Shoalhaven Practice Nurses!!!

26 September, 2008

Dear (electronic insert of practice nurse’s name from Shoalhaven Division of General Practice data base)

You are invited to participate in a local study on Shoalhaven Practice Nurses. This is your opportunity to share the experiences of your journey as a rural practice nurse!

Kathryn Godwin, a Master of Nursing –Research student at the University of Wollongong, is currently undertaking a study on ‘The retention of rural practice nurses’ in the Australian Rural General Practice Setting. We are looking to Rural Practice nurses to develop our understanding of what attracts rural practice nurses, if their expectations of the role are met, and what makes practice nurses stay. By identifying professional and personal issues in the rural general practice setting,
appropriate future policy development addressing rural practice nurse retention strategies can be developed. The Shoalhaven area is an area of particular interest and your support will be greatly appreciated. We are looking for practice nurses (Registered and Enrolled) who are currently working in a general practice.

The study involves a 30-45 minute interview about your experiences as a rural practice nurse in terms of professional (preparedness, professional development for your role in the private general practice) and personal (demographic and social) factors of the rural setting. Not all volunteer participants will be interviewed. The interview participants will be randomly selected from rural practice nurses within the Shoalhaven Division of General Practice.

Your involvement in the study is voluntary and you may withdraw from the study at any time, and withdraw any data that has been provided to that point. As a participant in this research you will need to be identifiable for further contact regarding an interview. However, it is important that you understand that the data collected from the interview, will be de-identified. Confidentiality is assured, and you and your employer will not be identified in any such reports as all data will be pooled so no individual can be identified. All data will be stored on the university premises in a locked cupboard/filing cabinet for a period of 5 years, and then securely destroyed, as per the University Code of Practice-Research.

Rural practice nurses are a rapidly growing workforce and this study will provide important information for future policy development addressing rural practice nurse retention strategies. Findings from the study will be collected by the researcher in the form of voice recorded interview. Data will be analysed with computer software, and then used in a thesis submission for Master of Nursing -Research at the University of Wollongong. The researcher has financial support from the Australian Practice Nurse Association post graduate scholarship scheme. The report of the study may be
published, presented at conferences and in a report to the Australian Practice Nurses Association. Participating nurses have the option to receive an individual feedback report about the findings of this study. The results will not be presented/published in a manner that will identify Shoalhaven Practice nurses specifically. Information and results from the research will be discussed at a practice nurse meeting held through the Division of General Practice following collation of the results.

ETHICS REVIEW AND COMPLAINTS
This study has been reviewed by the Human Research Ethics Committee (Social Science, Humanities and Behavioural Science) of the University of Wollongong. If you have any concerns or complaints regarding the way the research is conducted, you can contact the Ethics Officer, on (02) 4221 4457.

If you are willing to take part in this research, please complete the enclosed consent form, and return it to Ms Teresa Masterson in the reply paid envelope provided to you. You may keep this information sheet. Please do not hesitate to contact me should you have any concerns about this research project.

For further information contact;

<table>
<thead>
<tr>
<th>Researcher</th>
<th>Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Kathy Godwin</td>
<td>Professor Patrick Crookes,</td>
</tr>
<tr>
<td>Student Master of Nursing-Research</td>
<td>School of Nursing, Midwifery and Indigenous Health,</td>
</tr>
<tr>
<td>School of Nursing, Midwifery and Indigenous Health,</td>
<td>University of Wollongong</td>
</tr>
<tr>
<td>University of Wollongong</td>
<td>Telephone 02 4221 3339</td>
</tr>
<tr>
<td>Telephone 0409322590</td>
<td>Email;<a href="mailto:patrick_crookes@uow.edu.au">patrick_crookes@uow.edu.au</a></td>
</tr>
<tr>
<td>Email <a href="mailto:keg606@uow.edu.au">keg606@uow.edu.au</a></td>
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</tr>
</tbody>
</table>

Many thanks for your interest! Kathy Godwin.

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Appendix 2

Faculty of Health and Behavioural Sciences
School of Nursing, Midwifery and Indigenous Health

Consent form for Participation

THE RETENTION OF RURAL PRACTICE NURSES

I have been given information about an interview on ‘The retention of rural practice nurses’ by Kathryn Godwin, who is conducting this research as part of a Masters of Nursing- Research degree supervised by Professor Patrick Crookes in the School Nursing, Midwifery and Indigenous Health at the University of Wollongong.

I have read the Participatory Information Sheet. I have been advised of the potential risks and burdens associated with this research, which includes an opportunity to participate in a 30-45 minute interview. I have had an opportunity to ask any questions I may have about the research and my participation. I understand that I may be selected for this interview from all willing participants. I understand that I will remain anonymous in the results collected. My answers will remain confidential.

I understand that my participation in this research is voluntary, I am free to decline to participate and I am free to withdraw from the research at any time. My refusal to participate or withdrawal of consent will not affect my relationship with my employer, the Shoalhaven Division of General Practice, or the University of Wollongong.

If I have any enquiries about the research, I can contact either the student, Mrs Kathryn Godwin, or the supervisor Professor Patrick Crookes;

Mrs Kathryn Godwin
Phone 0409322590
Email keg606@uow.edu.au

Professor Patrick Crookes
Phone 02 4221 3339
Email patrick_crookes@uow.edu.au
If I have any concerns or complaints regarding the way the research is or has been conducted, I can contact the Ethics Officer, Human Research Ethics Committee, Office of Research, University of Wollongong on 4221 4457.

By signing below I am indicating my consent to

- A 30-45 minute interview if selected.
- The use of the transcript from the interview is to be used as research data.

I understand that the data collected from my participation will be used for future planning considerations in rural practice nurse retention. The results will not be presented/published in a manner that will identify Shoalhaven Practice nurses specifically. Information and results from the research will be discussed at a practice nurse meeting held through the Division of General Practice following collation of the results. Results will also be presented in a thesis and/or journal publication and I will not be identifiable in these presentations, and I consent for it to be used in that manner.

Please complete the attached page and return in the envelope provided. Thankyou!

Participants Signature……………………………………………………………………………………………………

............................................................................................. ....../..../……

Participant’s Name (please print) Date

Contact Details

Phone/email

......................................................................................................................................................................................

Preferred contact time, if any

......................................................................................................................................................................................

Thankyou, your participation is much appreciated. Please return this 2 page consent form in the envelope provided. It would be greatly appreciated if you could do so within 1 week of receiving your invitation to take part in this research opportunity.
Appendix 3

Characteristics of nurse participants

The following is a brief introduction to the seven practice nurses who were interviewed. This will provide the reader with information on the ages of the nurses, the hours they work, the enjoyable aspects and challenges in their role, and their family commitments.

Amelia
Amelia is 27 years old, working four days per week for three years in a task-orientated role in a large general practice, after working for one year postgraduate in operating theatres. Amelia finds her role a challenge and yearns for more professional respect from the GPs. Amelia enjoys the balance between work hours and providing caring for her busy toddler.

Mandy
Mandy is 48 years old, working three days a week with a solo, overseas trained GP for the last four years. She finds it challenging to maintain the status quo in her practice, often working as an interpreter and negotiator between the GP and patients. Mandy enjoys being home after-hours for her two teenagers.

Vicki
Vicki is 46 years old, working full-time five days per week in a large, busy general practice for over ten years. Vicki had previously worked in an urban general practice for five years. Vicki enjoys being business savvy, feels privileged in her role helping the community and enjoys time to attend sporting activities with her two children.

Christine
Christine is 31 years old, working full-time five days per week with a solo, overseas trained GP. Christine has been in her role for just under one year, since moving to a rural area for the first time. Christine enjoys creating her role utilising skills from her military background, developing a rapport with the clients and the convenience of working just around the corner form the primary school where her two children attend.
**Libby**
Libby is 46 years old, and works two days a week with her co-principal GP husband. Libby is a qualified midwife and enjoys working part-time in a varied role as a receptionist, practice manager and practice nurse. She finds that living out of the area achieves a life-work balance to attend all the after school activities with her three school-aged children.

**Jane**
Jane is 48 years old, and works full-time four and a half days per week for over five years. Previously, Jane had been working as a community nurse and holds a Certificate in Palliative Care. Jane enjoys “grooming” her role, and likes doing courses that support the business. She enjoys feeling valued by the GP, and has no family commitments.

**Michelle**
Michelle is 42 years old, and works part-time three days a week for over three years. Michelle is a qualified midwife and finds her role is integrated into a systematic business with friendly GPs. She enjoys working with great nurse “workmates” who help her to easily fit around commitments with her three school-aged children.
Appendix 4

Interview questions

1. **Demographic questions**
   - Age?
   - Sex?
   - Years as a nurse? Registered/enrolled nurse?
   - Any family commitments? If yes, number and age of dependants?
   - Hours working as practice nurse? Any other work?
   - Days usually worked? Weekdays/weekends?
   - Distance and time from home to general practice?
   - Years practice nursing?
   - GP : practice nurse : receptionist ratio

2. **Please tell me what attracted you to practice nursing?**
   - Prompt questions; were there professional reasons? Were there personal reasons like the rural community, lifestyle or social reasons?

3. **Explain what formal education you have had to prepare or support you in the practice nurse role? In retrospect, do feel this was adequate?**
   - Prompt questions; have you attended any courses since becoming a practice nurse? Have you had to develop any new skills since becoming a practice nurse? Do you think nurses coming to this area need any special education to prepare them for this role?

4. **(a) Do you feel rural practice nurse education is adequate for your professional development?**
   - Prompt questions; how is clinical supervision provided? Do you feel you are adequately supported by professional bodies? If so which ones? Do you feel adequately renumerated?
4. (b) Have you ever accessed any online resources? Have you ever used any online resources for learning?

5. Tell me, what do you think of living and working in your community?
Prompt questions; what do you like about it? What don’t you like about it? Does this affect your role as a practice nurse? Give me some examples.

6. Do you feel you are appropriately remunerated? Do you have any issues with getting your leave?

7. Do you intend to leave practice nursing?
Prompt questions; If so, when and for what reasons? If not, what makes you stay? Do you intend to retire as a practice nurse? If so, at what age do you intend to retire? What did you expect? Have your expectations been realised?
## Appendix 5
### Practice Nurse Roles

<table>
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<tr>
<th>Role</th>
<th>Tasks</th>
<th>Number of practice nurses that attended the task</th>
</tr>
</thead>
<tbody>
<tr>
<td>Novice</td>
<td>Wound care</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Home Health Assessments</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Minor Operation assistance</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>GP assistant</td>
<td>5</td>
</tr>
<tr>
<td>Extended</td>
<td>Triage</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Chronic disease care</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>PAP smears</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Immunisations</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>ECG</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Health Screening and patient education</td>
<td>2</td>
</tr>
<tr>
<td>Advanced</td>
<td>Emergency care</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Nurse led INR clinic</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Nurse led immunisation clinic</td>
<td>1</td>
</tr>
<tr>
<td>Non-clinical</td>
<td>Paperwork on behalf of GP</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Stock and supplies</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Reception duties</td>
<td>6</td>
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</tbody>
</table>