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Understanding collaboration in general practice: a qualitative study

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Understanding collaboration in general practice: a qualitative study

Abstract

Background: An increased incidence of chronic and complex conditions in the community is placing pressure on human resources in general practice. Improving collaboration between GPs and registered nurses may help alleviate workforce stressors and enhance health outcomes.

Objective: To explore the facilitators and challenges of collaboration between GPs and registered nurses in Australian general practice.

Methods: Eight GPs and 14 registered nurses from general practices in New South Wales, Australia, participated in semi-structured face-to-face interviews. Recordings were transcribed verbatim and underwent thematic analysis.

Results: The overarching theme 'Understanding collaboration in general practice' comprises four sub-themes, namely (i) interpreting collaboration in general practice, (ii) modes of communication, (iii) facilitators of collaboration and (iv) collaboration in practice.

Conclusion: Our findings suggest that regular, formal avenues of communication, professional development and non-hierarchical environments facilitated collaboration between nurses and GPs. Implementing strategies to promote these features has the potential to improve inter-professional collaboration and quality of care within primary care.

Disciplines

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Introduction

A global shift from acute, episodic care, towards the ongoing management of chronic illness has increased demand for general practice services (Van Lerberghe 2008, Crettenden et al. 2014). Securing an interdisciplinary workforce with the skills and expertise to deliver high quality care in this shifting climate is an ongoing issue for primary care providers internationally (Harris et al. 2007). Like other healthcare sectors, general practices are not immune to workforce stressors associated with labour supply, retention, and funding constraints (McInnes et al. 2017). International literature further suggests that an ageing workforce, burnout and an increased rate of part time employment are additional workforce stressors (Teljeur et al. 2010, U.S. Department of Health and Human Services 2013, Britt et al. 2014).

The World Health Organization actively promotes interdisciplinary collaboration to enhance the coordination and delivery of consumer centred primary care (Gilbert 2010). Among its many advantages, collaboration improves productivity within a growing climate of financial and human constraints (Mickan et al. 2010). Collaboration is most likely to succeed where there are effective modes of communication, role clarity and when team members share responsibilities, goals and decision making (D'Amour et al. 2005, San Martín-Rodríguez et al. 2005). While collaboration between GPs and allied health professionals, community pharmacists and NPs has been well investigated (Jove et al. 2014, Verger et al. 2014, Schadewaldt et al. 2016), there has been little research exploring collaboration between GPs and GPRNs (McInnes 2015). This is despite GPRNs comprising the largest group of nurses working in general practice both within Australia and internationally (Australian Medicare Local Alliance 2012, The Queen's Nursing Institute 2015).

Cost-effective strategies that enhance the coordination and delivery of client centred care are needed to meet the demands of an ageing population and increased prevalence of multi-morbidities(Gilbert 2010). Given these projected demands, it is timely to investigate collaboration between GPs and GPRNs. The aim of the overarching Project was to investigate the nature of collaboration between Australian GPs and GPRNs. This paper presents the theme 'Understanding collaboration in general practice' and explores the facilitators and challenges of collaboration in general practice. Due to the heterogeneity of themes and depth of data generated from the overarching Project, each theme is published separately. Other themes include the influence of funding models on collaborative practices(McInnes et al. 2017), and understanding the GPRN's role(McInnes In press).

Methods

This project used naturalistic inquiry to investigate collaboration between GPs and GPRNs(Lincoln and Guba 1985, McInnes 2016). Sitting within a constructivist paradigm, naturalistic inquiry adopts qualitative methods, purposeful sampling and an inductive process of analysis to investigate a phenomenon in the time and context in which it occurred(Lincoln and Guba 1985, McInnes 2016).

Setting and Participants

This Project was conducted in two PHNs in New South Wales, Australia. These networks covered 56,363 km² and service a population exceeding 1.52 million(Australian Government Department of Health 2015). The two PHNs combine a mix of urban and rural areas(Department of Health 2016). Eligible participants were GPs and GPRNs who worked in a general practice that employed GPRNs for a minimum of one year. The PHNs emailed a recruitment advertisement to general

practices and requests for participants were placed on industry websites. The lead researcher (SM) attended professional development meetings to further explain the project. Interested persons contacted the lead researcher who arranged a mutually convenient time to conduct individual, face-to-face interviews. Although incentives have previously been found to improve recruitment (VanGeest et al. 2007), limited funding meant that incentives to participate were not offered.

Data Collection

A literature review and a priori discussions with key experts in qualitative methods and general practice research informed the development of an interview guide (McInnes 2015). Interviews were conducted between February and May 2015 in a private space within the participants' place of work. Face-to-face interviews were chosen to facilitate a rapport between the researcher and participant and to provide visual cues to participant responses (Irvine et al. 2013). Semi-structured interviews provided the scope to use prompts to elicit additional information and to clarify responses. An individual interview format was selected to facilitate participants to reveal information about the nature of collaboration they experienced without concerns over confidentiality. All participants were provided with an information sheet detailing the purpose of the study and the researcher's role, and signed an informed consent prior to the interview.

Data Analysis

Digital audio recordings of interviews were transcribed verbatim by a professional transcription company. To ensure confidentiality, all identifying data were removed from the transcripts. Thematic analysis as described by Braun and Clarke (Braun and Clarke 2006), commenced after the first interview and continued until data saturation

was achieved. The researchers elected to not conduct member checking which has previously been disputed as a credible source to assess trustworthiness (Berkenkotter 1993, Sandelowski 1993). Transcripts were checked for accuracy against audio recordings, imported into NVivo 10™ and coded by one researcher (SM). Codes were cross-checked and confirmed by two other researchers (KP & EH). Sub-themes were robustly discussed until consensus was reached.

Results

Participant Characteristics

General practitioners (n = 8; 36%) and GPRNs (n = 14; 64%) were recruited from 13 practices. Half of the GP participants and all GPRN participants were female. The average age of GPs was 54.5 years and GPRNs 49.6 years. GP participants had worked in general practice between 2 and 35 years (average 20.25 years), and GPRN participants had an average of 8.6 years' experience working in general practice. Project demographics are presented in Table 4.1. Remoteness classification was based upon the Australian Standard Geographical Classification (ASGC-RA 2006) (Department of Health 2016). There are no remote or very remote general practices in either participating PHN.

Table 4.1: Practice Demographics

Practice Size		
Solo GP practice		2 (15%)
Duo GP practice		1 (8%)
Group practice		10 (77%)
Remoteness classification		
RA1	Major city	6 (46%)
RA2	Inner Regional	6 (46%)

RA3	Outer regional	1 (8%)
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Thematic Structure

The overarching theme: Understanding collaboration in general practice provides an overview of the collaborative experiences of GPs and GPRNs. Four sub-themes emerged, namely; i) Interpreting collaboration in general practice, ii) Modes of communication, iii) Facilitators of collaboration and, iv) Collaboration in practice.

Interpreting Collaboration in General Practice

All participants perceived that they collaborated. It was evident, however, that there was no common definition of collaboration and that most participants considered collaboration and teamwork to be interchangeable concepts. *“Not sure of the technical definition, they probably seem pretty similar”* (GP5).

“I think they're one and the same. I mean I know in teamwork each person has their clearly defined role. But in a multidisciplinary team it's the same” (GPRN11).

Those participants who perceived differences described various intricacies between the two concepts. For example, working together was considered teamwork, while collaboration required the exchange of ideas, the coordination of care between practitioners and interprofessional awareness.

“I think teamwork means a group of people just working together with a patient or whatever. Collaboration means I think input of ideas and talk about them and decide about the care” (GPRN12).

“Well, collaboration is working as a team. But I think it's also respecting the fact that the nurses have their own knowledge base” (GP7).

Other participants perceived that differences between collaboration and teamwork were related to professional backgrounds.

“I think collaboration for me is working between disciplines. So the nurses with the GPs, with allied health. Whereas teamwork in my case is the nursing team works really well together” (GPRN10).

All narratives revealed that the key focus of working together was to optimise outcomes;

“Just working together for the common good. For the best outcome for our patients” (GP6).

Modes of Communication

Clear and open communication were described as pre-requisites to effective collaboration between GPs and GPRNs. *“If there's good communication, that really helps” (GP2).* Despite this, most participants described *ad hoc* modes of communication between GPs and GPRNs. These included informal 'door stop' meetings, instant computer generated 'pop-up' messaging and phone and email.

“They [GPRN] phone or they sometimes stick a message under the door” (GP5).

“If it's really urgent they'll [GPRN] ring. Just in case we've not got our eyes on the screen” (GP8).

While *ad hoc* communication addressed immediate needs, there were few formal opportunities for GPs and GPRNs to discuss longer term goals or decision making. Participants described how formal practice staff and clinical team meetings varied in frequency from none to bi-annual and were often segregated by discipline. Participants articulated that there was “*no need*” (GPRN14) for regular combined clinical team meetings, they were perceived as being a “*monumental waste of time*” (GP4) and were logistically difficult.

In contrast, participants from one practice described the importance of daily clinical meetings between GPs and GPRNs. Such meetings were seen as a vital component in quality care with GPs and GPRNs discussing goals, care coordination and management.

“we look at the list, who's coming in or who we saw yesterday. We talk about who we saw yesterday and what we're struggling with. What we're going to do about this, that and the other thing. So we call that a team meeting and we use that - and the nurses are invaluable” (GP6).

Formal team communication was also considered valuable in terms of developing trust.

“I know from what they say in our clinical meetings, I know what level they function at and I'm very happy. They make good calls and I trust their judgment” (GP6).

Facilitators to Collaboration

Several GP participants felt that post-registration nursing education was a positive adjunct to collaboration and could improve productivity.

“I think GPs should be encouraging the nurses to do as much as they can and train in as many different facets as they can, because it certainly helps with the efficiency of your practice. That reflects in your patient care as well” (GP1).

Despite having specialist post-registration training in areas such as diabetes education, midwifery and female sexual health, many GPRN participants felt that the full extent of their expertise was not utilised and that greater collaboration between GPs and GPRNs could facilitate this.

“I think if doctors don't feel threatened like if the nurse wants to run Well Women's [clinics] to help the practice - instead of feeling threatened by that - embrace letting the nurse do what she's trained to do” (GPRN5).

Many GP participants employed GPRNs who complemented existing team members and contributed towards a positive team culture. *“You've got to have someone that's able to really be a bit independent and be able to learn to sort of fit in”* (GP7). This positive team culture enhanced staff satisfaction and retention.

“I'm in this job because I'm really passionate about patient care.... So being part of a team where that's everyone's focus makes it really pleasant to come to work” (GPRN5).

Where it was evident, the use of inclusive language facilitated collaboration and promoted a positive team culture. As one GP commented; *“I mean we're just colleagues. We're peers”* (GP6). Likewise, a GPRN participant reported;

"I never have felt in this practice that I'm just the nurse. It's very much what we do in the practice - it's [GPs] practice but he refers to it as our practice, our patients" (GPRN5).

Collaboration in Practice

While all participants perceived they worked collaboratively, narratives provided limited evidence of collaboration between GPs and GPRNs. Rather than articulating working together, most narratives described parallel patient loads and cooperative interactions. Delivering care in this way revealed a tendency for GPs and GPRNs to work in isolation to each other.

“Really the nurses often operate as almost parallel practitioners, they have all of their appointments during the day and we have all our appointments in the day” (GP5).

Some GPRNs saw this level of autonomy as being evidence of their success as a GPRN.

“Well that's what I like about general practice that you can be a bit autonomous.... It's good because nurses have got a lot of knowledge and I think they should be able to use it” (GPRN12).

Complementing parallel consumer loads, many participants described cooperative interactions between GPs and GPRNs. These appeared to focus on task attainment and strategies that alleviated the GP's workload.

“if we have to fit in urgent appointments she [GPRN] will do some basic observations and take a basic history before I see the patient and then she can determine how urgent it is for me to see them” (GP3).

Several participants, however, did describe how GPs and GPRNs could work together to solve clinical problems.

“It might be that somebody comes in with something quite complicated, the nurse actually comes in and you've got two people able to solve a problem”
(GP5).

Discussion

Collaboration was largely perceived by participants as the exchange of ideas and expertise to improve consumer outcomes. In reality, most participants adopted *ad hoc* communication and carried parallel consumer loads. While parallel consumer loads provided the autonomy that appealed to many GPRNs, the dominance of *ad hoc* interactions between GPs and GPRNs did not facilitate the development of the fundamental features of collaboration around shared goals, decision making and responsibilities. In contrast, environments with a structured approach to team communication were able to incorporate these features into practice, improving the utilisation of nurses and creating a positive team culture.

Strengths and Limitations

This project provides unique insight in that it has explored collaboration from the perspectives of GPs and GPRNs. However, there are several limitations. Firstly, participants were recruited from a single Australian state. Despite this, practice demographics were reflective of other areas across Australia (Australian Government Department of Health 2015). Secondly, recruiting GPs is an ongoing concern (McKinn et al. 2015) and only eight GPs agreed to participate. While all GPs and GPRNs who met the eligibility criteria were invited to participate, practices receptive to research may have been more likely to respond. Therefore, participants with alternate views may not have been recruited. Finally, as a naturalistic inquiry, generalisations are not possible (Lincoln and Guba 1985); however, a detailed

description of the setting and participants facilitates the transferability of findings(Lincoln and Guba 1985, McInnes 2016).

Comparison to the Literature

Consistent with the literature around other health professionals, GPs and GPRNs in this project tended to conflate teamwork and collaboration into a single unity(Oandasan. et al. 2006, Xyrichis and Ream 2008, McInnes 2015). Although this is not unusual, clearly defining collaboration and teamwork may help establish policy frameworks that improve the way GPs and GPRNs deliver chronic care(Oandasan. et al. 2006). While McKinlay et al.(McKinlay et al. 2013) suggest that teamwork is ineffective in the absence of collaboration, the two certainly share unique manifestations around sharing goals, decision making and responsibilities(D'Amour et al. 2005). There are, however, subtle differences between collaboration and teamwork in approaches to hierarchy, leadership and autonomy(McInnes 2015). This may challenge collaboration in privately owned general practices which largely operate within a hierarchical business model with the GP as owner. Rigidly hierarchical environments are often incompatible with collaboration(Jansen 2008) and have previously been associated with fragmented care and poor team engagement(Fewster-Thuente and Velsor-Friedrich 2008, Reeves et al. 2011). This may potentially decrease GPRN satisfaction and cause significant cost to the organisation through increased staff turnover.

A recent review of the literature by Morgan et al.(Morgan et al. 2015), found that frequent and informal communication was crucial to establishing inter-professional collaboration. In contrast, findings from this project resonate with research conducted in NZ by Finlayson and Raymont(2012) which found that while frequent reactive

discussions serviced immediate needs in times of high workload they did not provide opportunities for participants to negotiate common goals or to share decision making and instead, led to parallel roles. Oandasan et al.(Oandasan. et al. 2006) and D'Amour et al.(D'Amour et al. 2005) report that parallel and autonomous practices are situated at the lower end of the collaborative spectrum and are associated with less interdependence between team members. While many GPRN participants were attracted to the autonomy that parallel roles provided, the lack of formal interprofessional interactions meant that care was not delivered in a co-ordinated or collaborative manner that has previously been identified to improve outcomes(Wagner et al. 2001, San Martín-Rodríguez et al. 2005).

Formal opportunities to communicate as a team accelerated the development of trust and facilitated an environment conducive to establishing a collaborative environment where participants could share goals and coordinate care. Reflecting the experiences of structured 'huddles' in other primary care environments where teams meet, formal clinical team meetings provided participants with opportunities to share decision making, facilitated care coordination(Chen and Brodie 2016) and provided opportunities for GPs and GPRNs to discuss potential workload and support needs(Leasure et al. 2013). While downtime to conduct formal team meetings required organisational commitment and represent a cost to the organisation(Fewster-Thuente and Velsor-Friedrich 2008), participants felt that formal team meetings positively influenced the quality of care, and the utilisation of GPRNs.

The increased prevalence of chronic conditions will require nurses to work to the full scope of their practice. Consistent with previous research conducted in Australia and Canada, GP participants were positive towards GPRNs gaining post-registration

qualifications; however, they appeared to lack clarity around the GPRNs' scopes of practice (Akeroyd et al. 2009, Allard et al. 2010, Halcomb 2014, Freund et al. 2015). It was apparent that the expertise of many GPRN participants was underutilised and that the full potential of their role has not yet been met. Role clarity is fundamental to effective collaboration and previous reports from this project suggest that poor role clarity is a significant issue impacting collaboration between GPs and GPRNs in Australian general practices (McInnes In press).

Implications for Practice

Understanding GPs' and GPRNs' perceptions of collaboration and the barriers and facilitators to working together is important to identifying how the primary care workforce can be strengthened. While collaborative practices have been identified as an effective model of care (Wagner et al. 2001), it is vital to its implementation that we understand the organisational and workforce implications unique to general practices. Such understandings will help improve the utilisation of nurses and the capacity of the general practice workforce. The challenge perhaps, is to create non-hierarchical teams within a hierarchical business model.

Conclusion

Findings from this project have the potential to maximise human resources and alleviate workforce stressors associated with the growth of multi-morbidity presentations in general practice. While collaboration is gaining recognition across health services, the business model of general practice differentiates this workplace from other health settings. It is evident that parallel workloads are common in Australian general practice and that GPRNs appreciate the autonomy that this provides, however, individual professional autonomy lacks the advantages offered by

collaboration. Non-hierarchical work environments that supported regular, formal communication provided the greatest opportunities for GP and GPRN collaboration.

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