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# AJAN

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# Reasons for entering and leaving nursing: an Australian regional study

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## KEY WORDS

Nurses, retention, recruitment, career choice, survey

## ABSTRACT

### Objective

To compare and contrast the reasons that nurses and nursing students provide for entering and leaving nursing.

### Design

A quantitative cross-sectional cohort design with online survey.

### Setting

Regional public health service district and regional university nursing school.

### Subjects

Nurses (n= 272) and nursing students (n=259).

### Main outcome measures

Demographics of nurses and nursing students including age, sex and length of time as a nurse, and reasons for entering and leaving the profession.

### Results

Among the nurses 88.4% were female and 37% 50 years of age or older. Almost half (45.3%) of the nursing students were 30 years of age or older and 44.1% of all students were working as nursing assistants or enrolled nurses whilst studying. Of these working students 32.5% had been nursing in excess of five years. Self interest, vocation and altruism were identified by both students and nurses as the main reasons for entering nursing. Respondents above and below 30 years of age gave the same reasons for entering nursing. Choice of factors for considering leaving nursing differed between groups and ages. Compared to students, nurses were most likely to cite *disillusionment with nursing*. Students under 30 years of age indicated *pursuit of another career* and *starting a family* to be the major factors while older students offered *disillusionment with nursing* and *health concerns*.

### Conclusions

Retention strategies may need to differ for the age of nurse. However, recruitment needs to be informed by the altruistic and vocational reasons why nurses and nursing students are drawn to nursing rather than focussing on perceived generational differences.



## INTRODUCTION

Despite recent increases the Australian nursing workforce continues to be undersupplied (Australian Institute of Health and Welfare 2008; Iliffe and Kearney 2006) and shortages are predicted to increase (Davis 2008; Gaynor et al 2007). From 2010 yearly demand is expected to be 10,000 new nurse graduates with a shortfall of 4,000 (Australian Health Workforce Advisory Committee 2004).

Absolute workforce numbers are influenced by determinants that may be grouped into the areas of recruitment, turnover and retention. Past studies have identified numerous influencing factors from the tangible such as pay, workload, convenience and family responsibilities, to the intangible such as job satisfaction, status and psychological rewards (e.g. see Eley et al 2007).

Reported reasons for entering nursing include caring for people, vocation, rewarding career, stepping stone to another career, family history of working in health, career security, previous work or socialisation experiences, job satisfaction, and interest in medicine or biology (Price 2009; Coombs et al 2007; Duffield et al 2004; Mills and Blaesing 2000; Fagerberg et al 1997; Foskett and Hemsley-Brown 1997; Wright and Sumar 1996; Land 1994; Murray and Chambers 1990). Altruism is a common theme throughout the studies.

A few studies have addressed the question of retention i.e. why nurses stay in nursing, and have identified multiple and varied factors. These include personal fulfilment, charity, professional development, attainment of seniority, stable and merit-based work environment, adequate staffing, high nurse to patient ratios, good community relationship, and autonomy (Donoghue and Castle 2006; Murrell-McMillan 2006; Cangelosi 2005, Anderson et al 2004; Duffield et al 2004, Francis et al 1992).

In order to determine factors which may influence departure from nursing most studies have measured intent. Variables contained within the categories of personal history (age, education), workplace (staffing, relationships), nursing practice

(autonomy), employment conditions (pay, professional development), job satisfaction (appreciation, psychological rewards) and safety (abuse, violence) have been identified (Morrell et al 2008; Eley et al 2007; Farrell et al 2006; Tourangeau and Cranley 2006; Summer and Townsend-Rocchiccioli 2003; Aiken et al 2002; Duffield and Franks 2002; Goodspeed 2002; Sochalski 2002).

Studies in the United Kingdom (UK) and United States of America have identified pay as an important factor to nurses leaving the profession (Sochalski 2002, Robinson et al 1999); however other studies in Australia, UK and Sweden suggest that pay is not a main factor affecting departure (Frijters et al 2007, Sjögren et al 2005; Duffield et al 2004, Morrell et al 2004, Nursing and Health Services Research Consortium 2001). Overall, results suggest that the reasons for leaving nursing are both variable and complex supporting the theory that a combination of factors brings nurses to the point where a single action – ‘the shock’ - tips the balance (Morrell 2005).

Over the last decade Generation Y has entered the workforce and Australia has experienced considerable economic fluctuations. We questioned whether the reasons nurses and nursing students enter and leave the profession would reflect those events. The study reported herein surveyed nurses and nursing students to determine their reasons for entering the profession, their intended retention and reasons that would influence departure. The paper also presents important information on the demographic profile of nursing students.

## METHODS

### Design

The study was undertaken in March 2009 and used a quantitative cross-sectional cohort design. Approval was obtained from both the university and health service ethics committees.

### Participants

Potential participants were approximately 800 nurses (registered and enrolled nurses) employed in the public health services of a regional health service district of Queensland and 442 nursing



students enrolled in a Bachelor of Nursing degree at a regional Queensland university. The health service and university invited participation by email to all their nurses and students, respectively. Recipients who chose to participate were instructed how to gain access to the on-line survey instrument.

### Materials

The on-line instrument collected information on age, sex, nurse designation, main job, length of time as a nurse and anticipated time in nursing. Participants were also asked to identify up to three of 17 offered reasons for entering nursing and up to three of nine offered factors that would influence them to leave nursing. The offered options were created from prior surveys undertaken by the authors (Hegney et al 2008) and the extant literature.

### Analysis

Descriptive statistics summarised the data. All comparisons were undertaken on an item-by-item basis and differences assessed by chi-square and Z-test for two proportions. An alpha level of 0.05 was required for significance.

## FINDINGS

### Response rate

It was not possible to determine the exact number of nurses who received the invitation to participate; however based on a maximum number of 800 the minimum response rate was 32.3% (n=259). For students the exact number of recipients was known and the response rate was 61.4% (n=272).

### Demographic information

Respondents were predominantly female (table 1). Nurses were older; however 45.2% of the students were 30 years of age or older. Almost half of the students (44.1%) were working whilst studying, mostly on a part time or casual basis as enrolled nurses, or assistants in nursing/personal carers (AIN/PC). Working students were more likely to be older than non-working students ( $\chi^2 = 13.54$ , df 4,  $p = .009$ ). Overall nurses had been working longer than working students ( $\chi^2 = 164.61$ , df 5,  $p < .001$ ); however 32.5% and 17.6% of working students had been working in nursing in excess of five and ten years, respectively.

**Table 1: Demographic information.**

	Students		Nurses	
	n	%	n	%
Male	23	8.5	30	11.6
Female	249	91.5	229	88.4
Total	272	100.0	259	100.0
< 20 years	38	14.0	0	0
20 - 29 years	111	40.8	17	6.6
30 - 39 years	50	18.4	42	16.2
40 - 49 years	56	20.6	104	40.2
50 - 59 years	17	6.3	77	29.7
60 + years	0	0	19	7.3
Aboriginal/Torres Strait	11	4.1	3	1.2
Working in nursing	120	44.1	241	95.6
full time	18	15.5	136	56.0
part time	49	42.2	98	40.3
casual	49	42.2	9	3.7
Year worked as a nurse				
less than 1	22	19.3	4	1.6
1 - 2	29	25.4	0	0
2 - 5	26	22.8	13	5.3
5 - 10	17	14.9	27	10.9
10 - 15	9	7.9	28	11.3
over 15	11	9.7	175	70.8
Job position				
RN	0	0	210	85.9
EN	24	20.7	22	9.0
AIN/PC	87	74.9	5	2.0
other	5	4.8	5	2.0

### Factors influencing decision to become a nurse

Each respondent could choose up to three of 17 offered factors. The same five factors associated with self interest, vocation and altruism were ranked highest by both students and nurses (table 2). The second set of factors (ranked 6-10) also ranked similarly between groups; however prospect for career progression was chosen by more students (29.2%) than nurses (10.0%;  $z = 5.386$ ,  $p < .001$ ).

There were insufficient data to compare nurses under and over 30 years of age. With the exception of the response to *nursing is my vocation in life* comparison of nursing students above (n=149) and below 30 years of age (n=123) revealed no differences (in all cases  $p > .1$ ) in factors for becoming a nurse. *Nursing vocation* was chosen by 32% of students under 30 years of age compared to 51% of students 30 years or older ( $z = 2.802$ ,  $p = .005$ ).

**Table 2: Factors influencing the decision to become a nurse.**

Factor*	Student		Nurses		All	
	n	rank	n	rank	n	rank
I find the work interesting	122	1	121	1	243	1
Opportunity for caring	116	2	96	3	212	2
Opportunity to work with people**	94	4	109	2	203	3
Nursing is my vocation in life	101	3	78	4	179	4
Sense of giving to the community**	88	5	45	5	143	5
Prospects for career progression**	79	6	26	10	105	6
Flexibility of working hours	46	7	40	6	86	7
Financial incentives	45	8	35	8	80	8
Availability of employment	41	10	37	7	78	9
Job is suited to my lifestyle and responsibilities	42	9	29	9	71	10
No interest in any other type of employment	19	11	16	13	35	11
Relationships with colleagues in health sector	18	12	17	12	35	12
Teaching opportunities	17	13	18	11	35	13
Proximity to home	8	15	10	14	18	14
Opportunities to do research	15	14	3	16	18	15
Low confidence in looking for other employment	4	16	9	15	13	16
Child care reasons	1	17	1	17	2	17

\* up to three options could be selected

\*\* significant difference ( $p < .05$ ) between nurses and students

### Anticipated future time in nursing

The anticipated time in nursing (table 3) differed between the two groups ( $\chi^2 = 98.546$ ,  $df 5$ ,  $p < .001$ ) with the main effect that students expect to be in nursing longer than the nurses.

**Table 3: Anticipated future time in nursing.**

Anticipated future time in nursing	Students		Nurses	
	n	%	n	%
less than 1 year	0	0	2	.8
1 - 2 years	5	1.9	5	2.1
2 - 5 years	12	4.7	39	16.2
5 - 10 years	15	5.8	64	26.6
10 - 15 years	42	16.3	50	20.7
Over 15	147	57.0	56	23.3
Unsure	37	14.3	24	10.0

### Factors affecting decision to leave nursing

Respondents were asked to choose up to three of nine factors that would influence their decision to leave nursing. Results are presented in table 4 for the 154 students and 138 nurses who responded to the question. Choices were different between groups

for several of the factors. Nurses saw *disillusionment* as their highest factor, closely followed by *retirement*. *Career progression outside of nursing* was highest rated by students. *Health*, which was a factor for students to consider leaving nursing, was not ranked highly by nurses.

**Table 4: Factors influencing respondents' decision to leave nursing.**

Factors*	Students		Nurses	
	n	rank	n	rank
See career beyond nursing**	58	1	36	3=
Health concerns**	47	2	25	8
Family responsibilities	46	3	31	5
Plan to start a family**	41	4	12	9
Dislike of shift work	38	5	36	3=
Disillusionment with nursing**	36	6	77	1
Earn more money elsewhere	35	7	31	5
Retirement**	13	8	69	2
Nothing left to give**	12	9	29	7

\* up to three options could be selected

\*\* significant difference ( $p < .05$ ) between students and nurses

Between working and non working students the only factor that differed was that for *disillusionment with nursing* with those who were working more likely to select this choice than those who were not working (20% vs 7.5%;  $z=2.833$ ,  $p=.005$ ).

Responses to several factors differed for students below 30 years of age compared to older students. The latter were more likely to choose *disillusionment with nursing* (18.6% vs 8.7%;  $z=2.238$ ,  $p=.025$ ) and *health concerns* (22.7% vs 12.7%;  $z=2.012$ ,  $p=.044$ ), while younger students chose *plan to start a family* (25.5% vs 2.4%;  $z=5.12$ ,  $p<.001$ ) and *career beyond nursing* (28.8% vs 12.1%;  $z=3.19$ ,  $p=.01$ ).

## DISCUSSION

The study provides information from one region in Queensland. Although some the results will be of no surprise to the reader others may be, and should inform recruitment and retention strategies.

Surprisingly little is known about the demographics of the Australian student nursing population. It was this deficiency that prompted establishment of the Nurses and Midwives e-cohort study (<http://nurses.e-cohort.net/>). Our student population's age, sex and Indigenous representation are in agreement to those reported from the seven Queensland nursing schools in that study (Gaynor et al 2007). However the percentage of students with enrolled nurse qualifications was higher than in the two schools in the e-cohort study for which data were presented.

For the nurses demographics were comparable with those from studies of Queensland Nurses Union members (Hegney et al 2008) and with government data for Queensland (Australian Institute of Health and Welfare 2008). Overall the data confirm an ageing and still predominately female workforce with little Indigenous representation.

There are recruitment implications to the opportunity for studying on a part time basis (Gaynor et al 2007). In keeping with trends observed anecdotally over many years, among the nursing students close to half are working part time in nursing. Whether work was for

financial reasons or to gain work experience was not determined, however was enabled by emphasis within the university on flexible study options designed to help students manage competing study, work and family obligations.

The fact that a third of students had been working in nursing in excess of five years is an important finding. One in five of the students who worked were ENs whilst 75% were working as AIN/PC; unregistered nurses who make up around 15% of Queensland's nursing workforce (Queensland Nurses' Union 2008). Enrolment of these nurses in a degree program could reflect success of renewed emphasis within the profession on better articulation of educational pathways. However as the specific motivation of these students to enrol in a registered nursing programme was not determined future research is required to confirm this.

The highest ranking factor for entering nursing was interest in the work followed by four altruistic factors. The latter were the highest ranked reasons for entering the profession in another Australian study (Duffield et al 2004).

The generally accepted belief is that Generation Y is different and wants more lifestyle choices than previous generations. It is implied that this will affect recruitment and retention of nurses (see for example Francis 2009; Jamieson 2009). However in our study there was remarkable consistency between the students and the nurses, and between students above and below 30 years of age in the ranking of the factors that influenced their decision to become a nurse. This is an important finding, and challenges assumptions that younger people will only be drawn to nursing if it offers them an appealing lifestyle.

These findings question recruitment messages formulated with consideration of likely differences between generations. Notions that young people are 'turned off' a career in nursing because supposedly old-fashioned values of altruism and vocation have no interest to them have led to tailoring nursing recruitment messages accordingly. These concepts appear in nursing recruitment

campaigns, such as Queensland's 'Think Nursing' (<http://www.thinknursing.com/>; accessed 15.01.10) where prospective nurses are told that nurses will enjoy financial rewards, professional and career development, a flexible workplace and a 'dream Aussie lifestyle'. Certainly these attributes are important recruitment messages; however the results of the current study suggest that the emphasis may need to be questioned. Perhaps, after all, young people are drawn to nursing for exactly the same reasons as previous generations. That is a desire to care for others. Planned in-depth interviews will explore this further.

Whilst accepting that intent to leave the profession does not necessarily equate to subsequent action (Morrell 2005), the questions we posed have been used in repeated studies in Queensland (see Hegney et al 2008 for citations), and provide the opportunity for comparison. Results in this study for intention to remain in nursing are comparable to those reported for 2001, 2004 and 2007 across Queensland (Hegney et al 2008).

Of particular interest was that over 40 percent of students anticipated staying in nursing less than 15 years. Given that over 90% of the students were under 50 and may be expected to be working for at least 15 years this projection is somewhat alarming and poses questions for retention strategies.

Personal factors for leaving largely concurred with other studies with main factors of raising a family and nursing seen as a stepping stone for a future career (Eley et al 2007; Sjögren et al 2005; Duffield and Franks 2002). However within the student cohort those who were older including many with nursing experience saw disillusionment and health as key factors. That health concerns was a projected reason for departure for the students and not the nurses is an area for which further study is planned.

## CONCLUSIONS

It is essential for workforce planning that the factors contributing to recruitment and retention are known. Recruitment strategies should avoid unsupported assumptions about generational differences and

choice of careers, and instead focus on nursing as a career choice for those who want to care for others. Recruitment campaigns may need to be more clearly targeted to reflect these findings.

Trends to more mature aged students in nursing, and nursing students either having prior experience in nursing, or working in nursing whilst studying for their bachelor in nursing, suggest that retention strategies need to target all participants in nursing work, regardless of their status or extent of involvement in nursing.

Further, if nurses enter nursing because they want to care, then perhaps a subsequent decision to leave nursing because of a sense of disillusionment could mean that nursing work environment did not sufficiently allow or value a caring ethos. Retention strategies should identify and attend to the sense of disillusionment which leads nurses to leave nursing, in light of their reasons for entering nursing in the first place (a desire to care for others).

## LIMITATIONS

In designing the study the authors were aware it would not be possible to ascertain the exact number of nurses receiving the invitation to participate because the survey had to be distributed by third parties. The intent of the study was to have enough subjects (estimated at 400) to make comparisons among students and nurses for a power of .80 at alpha .05. The authors received 531 responses with power greater than 0.99 which exceeded their estimation.

The study does have bias around the self-selected nature of participation and results reflect only the views of nurses and nursing students from one region in Queensland. Furthermore, as with any cross sectional study measuring variables at one point in time it cannot be assumed that the sample characteristics are constant.

Despite these limitations the data presented in this study do contribute to evidence about the future nursing workforce; evidence which has been noted as "central to ensuring appropriate workforce planning strategies" (Gaynor et al 2007).

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# An analysis of nurses' views of harm reduction measures and other treatments for the problems associated with illicit drug use

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## KEY WORDS

illicit drugs, nurse, education, harm reduction, abstinence

## ABSTRACT

### Objective

To analyse nurses' views of harm reduction measures and other treatments for the problems associated with illicit drug use.

### Design and setting

The study, a cross-sectional survey, sampled the entire registered nurse population of the ACT. A self-complete survey was posted to home or workplace addresses. The views of all nurses registered in the ACT were sought.

### Subjects

The study sample ( $n = 1,605$ : 50% response rate), was predominantly comprised of nurses working outside specialist drug and alcohol fields (94%), with a small group from specialist fields.

### Main outcome measures

A 6-point Likert scale comprising 7 items (illicit drug treatments). Comparison with the Australian population was achieved through use of the National Drug Strategy Household Survey database.

### Results

Nurses mirrored the views of the Australian population, being strongly supportive of two abstinence-based measures (naltrexone for the maintenance of abstinence – 82% and rapid detoxification therapy – 77%) and one harm reduction measure (the needle and syringe program – 76%). Nurses' lower support for the methadone maintenance program (66%) was statistically significant.

### Conclusions

Nurses reported high approval for the needle and syringe program but were mistakenly optimistic about abstinence-based measures for problems associated with illicit drugs. They reported significantly less support for important harm reduction measures – the methadone maintenance program and safe injection rooms. Nurses' low approval rating for these harm reduction measures is at odds with the evidence. This study highlights the need for education on the evidence base for the various illicit drug treatments.



## INTRODUCTION

The last decade has seen a greatly increased scientific knowledge base concerning harm reduction measures and other treatments for individuals who use illicit drugs. Harm reduction measures aim to both minimise drug-related harm (for example, needle and syringe programs and supervised injection facilities) and lessen the demand for illicit drugs (for example, methadone maintenance programs). In contrast to harm reduction measures, abstinence-based measures focus on the cessation of illicit drug use (drug-free detoxification, the use of naltrexone in rapid detoxification therapy and naltrexone maintenance therapy for relapse prevention).

In Australia, illicit drug users (IDUs) are regular attendees at emergency departments (Krenske et al 2004) and general wards in the acute hospital sector (Tait et al 2002; Roxburgh and Degenhardt 2008). Therefore registered nurses working in non-specialist drug and alcohol areas are well positioned to play their role in assisting drug users to reduce the harms associated with illicit drug use. It is not clear, however, how these nurses view harm reduction measures and other treatments for the problems associated with illicit drug use.

The author's previously published study (Ford et al 2008, 2009) investigated registered nurses' therapeutic attitude to patients who use illicit drugs. The sample unit was the entire registered nursing workforce in the ACT. The study sample ( $n = 1,605$ ) was 50% of the available nurse population, comprised predominantly of registered nurses working outside 'specialist' drug and alcohol fields, inclusive of medical/surgical, intensive care, emergency, midwifery, pediatrics, education and management, and others such as gerontology and community. A small segment of the study sample (6%) was from 'specialist' fields, namely, drug and alcohol and mental health. The authors found nurses' therapeutic attitude to be constrained by low levels of role support and drug education (Ford et al 2008). The authors found role support, and the combination of drug and alcohol education and role support, to be significantly associated with higher

therapeutic attitude (Ford et al 2008, 2009). Nurses' personal characteristics (age, sex, education level and religiosity) were found to have no association with therapeutic attitude, while a negative attitude to illicit drugs was marginally significant (Ford et al 2008). The current paper takes this investigation further by analysing the same nurses' views on harm reduction measures and other treatments for problems associated with illicit drug use.

## LITERATURE REVIEW

Australia's early articulation of a harm minimisation philosophy in response to the problems associated with illicit drug use established it as a world leader in drug policy (Single and Rohl 1997) and was credited with 'containing the spread of HIV/AIDS more successfully than almost any other country' (Premier's Drug Advisory Council 1996, p. iv). The current drug policy, the National Drug Strategy: Australia's Integrated Framework, 2004 – 2009 (Ministerial Council on Drug Strategy 2004) continues to articulate harm minimisation as a guiding principle in all areas of action. 'Harm reduction', a clearly stated aim of the harm minimisation philosophy, refers to a number of health strategies focused on reducing the adverse consequences of illicit drug use in the event that drug use continues (Ritter et al 2004). Harm reduction strategies have been found to reduce drug-related harm and drug dependencies (Reuter and Pollack 2006) and drug-related hospital admissions and costs (Riddell et al 2008).

One important implication of this policy environment is the need for registered nurses to practice within a harm reduction framework, in which the role of harm reduction measures is clearly understood and valued. However, while a number of studies have assessed specialist addiction workers' attitudes to harm reduction measures, no studies were located which had a focus on registered nurses' understanding of, or attitudes to, harm reduction strategies. In their Canadian study ( $n = 925$ ) Ogborne and Birchmore-Timney (1998) found a high approval rating for the needle and syringe program amongst specialist staff (82%). The trial of prescribed heroin

was less popular (15% - 35%), although support was higher from specialist staff working in assessment/referral (61%) and outreach programs (61%). In the United States of America, Forman et al (2001) investigated beliefs about treatments for addiction in a sample of staff ( $n = 317$ ) working in a variety of treatment centres. They found a low percentage of staff endorsed methadone maintenance (34%), while more staff (46%) agreed that patients who failed to maintain abstinence from illicit drugs should be discharged from treatment. This finding concurs with an early Australian study by Caplehorn et al (1996) ( $n = 90$ ), in which evidence of an abstinence-based ideology was found amongst some staff working in methadone maintenance programs.

#### **Harm reduction measures: the evidence**

The needle and syringe program (NSP), a well-established harm reduction strategy, provides injection drug users with free sterile needles and syringes and education about safe sexual and injection behaviour (Wood et al 2002). NSPs are viewed as an appropriate and pragmatic harm reduction response to disease transmission and are credited with reducing Australia's prevalence of human immunodeficiency virus (HIV) among IDUs (Law and Batey 2003). Program involvement has also been found to prompt illicit drug users to enrol in treatment and thus reduce drug use and injecting behaviour (Kidorf et al 2009).

By allowing space and time for an IDU to inject their pre-purchased illicit drug as safely as possible, a supervised injection facility (SIF) aims to lessen drug overdose, disease transmission and public drug seeking, trading and disposal conduct (Small et al 2006). Opening in Sydney in 2001, Australia's Medically Supervised Injecting Centre has been shown to attract marginalised IDUs and engage them with health and social services (van Beek 2003) and to play a role in reducing both the prevalence of HIV in the drug-injecting heterosexual community (Salmon et al 2009a) and injection-related injury and disease (Salmon et al 2009b). An injection facility affords nurses the opportunity to assess and treat an IDU's infections, to refer her/him to appropriate health and

drug treatment services (Small et al 2008) and to educate her/him about safer injecting practices, for example, 'how to find a vein and tie off properly, how to cook and filter drugs, how to inject safely' (Wood et al 2008, p.186). Nurses particularly target those at most risk of harm, ie females, sex workers and those who inject publicly, borrow/lend syringes, require help to inject and/or binge on illicit drugs (Wood et al 2008). These improved health outcomes for IDUs who use the Sydney-based safe injection facility have also been shown in Canada (Kerr et al 2007) and Europe (Bravo et al 2009).

An important harm reduction measure, the methadone maintenance program, has been operating in Australia since the early 1980s and a strong evidence base for its efficacy is well documented. For example, in a review of six randomised controlled trials of methadone maintenance therapy versus non-opioid therapies (drug-free detoxification and rehabilitation) Mattick et al (2005) found methadone maintenance therapy to be more effective in keeping heroin dependent individuals in treatment and limiting their heroin use. As well as reduced heroin use, Gowing et al (2005a) found a reduced incidence of high-risk sexual and injecting behaviours, which also limited HIV infection.

#### **Abstinence-based measures: the evidence**

Naltrexone, an opioid antagonist, is used to achieve rapid detoxification from opiates in an anaesthetised or heavily sedated patient. Evidence of the efficacy of this treatment remains inconclusive. Gowing et al's (2005b) review of clinical trials found problems with comparability, such as inconsistencies in the amounts of opioid antagonist and other medications used, differing durations of anaesthesia and lack of information on referral and long-term outcomes.

Naltrexone maintenance therapy is used to assist heroin dependent individuals maintain abstinence once they have completed detoxification (naltrexone blocks the effect of heroin and other opioids). Adi et al (2007) conducted meta-analysis of studies evaluating the efficacy of adjunct naltrexone therapy in preventing relapse to drug use following withdrawal. Although some studies found a link with abstinence

maintenance, the evidence was considered poor and the wide use of naltrexone to maintain abstinence was not recommended by these authors.

### **Implications for the nursing role**

There is compelling evidence for the efficacy and effectiveness of harm reduction measures. Illicit drug users however are generally reluctant to access treatments and to maintain communication with health personnel (Ostertag et al 2006), therefore limiting the capacity of health personnel to offer assessment, advice and referral. Given their high exposure, registered nurses are in an ideal position to offer opportunistic brief interventions including harm reduction advice to this marginalised patient group. However, there is no evidence to date in Australia about how nurses view harm reduction measures and other treatments for illicit drug use. Gathering this evidence is an essential first step in nursing workforce development.

The survey tool for the main study included one variable from the National Drug Strategy Household Survey (NDSHS). The variable for analysis was 'Views on a range of measures for problems associated with illicit drug use'. There are seven items in this variable that cover a diverse range of approaches to managing the problems associated with illicit drug use. Rapid detoxification therapy and the use of naltrexone are both treatments that focus on maintaining abstinence from illicit drugs. The remaining five measures fall within the harm reduction paradigm. They include two well-established harm reduction measures, namely, the needle and syringe program and the methadone maintenance program, and three new measures, namely, treatment with drugs other than methadone, regulated injection rooms and prescribed heroin.

The NDSHS is conducted every two years in Australia; therefore, the NDSHS variable used in this study is considered a valid tool for measuring nurses' views. The NDSHS survey was conducted just prior to data collection for this study, therefore, in the absence of other findings to compare against, the study findings are compared with the Australian population, via the raw data held in the NDSHS database.

Study objectives:

1. to analyse nurses' views on harm reduction measures and other treatments for problems associated with illicit drug use; and
2. to analyse the extent to which nurses' views conform with those of the Australian population.

### **METHODOLOGY**

The findings reported here are part of a mixed-methods study of nurses' therapeutic attitude to patients who use illicit drugs, undertaken in the ACT. The study, a cross-sectional survey ( $n = 1,605$ ) was approved by The Australian National University Human Research Ethics Committee and data were collected in 2003. The study established the importance of role support and the combination of role support and drug education in facilitating nurses' therapeutic attitude (Ford et al 2008, 2009). The final part of the study, reported here, examines nurses' views on harm reduction measures and other treatments for the problems associated with illicit drug use.

#### **Sample**

The study used the ACT Nurses Registration Board Roll as the sample frame. The sample unit comprised all registered nurses on the Roll ( $n = 3816$ ) (enrolled nurses were not included in this study). Non-clinical nurses such as educators, managers, policy advisors and researchers are influential within the nursing community (Eliason and Gerken 1999), therefore the views of non-clinical and clinical nurses, were considered important in this study.

Questionnaires were mailed in two waves, predominantly to nurses' home addresses but also work address. The final response to the postal survey ( $n = 1605$ ) was 50% of the eligible sample (the eligible sample was 3,241 - 575 members of the sample unit were ineligible due to overseas travel, retirement or invalid address).

In summary, the study sample was predominately female (94%) with a mean age of 44 years ( $\pm 9$ ). A large majority of the sample (77%) was engaged in clinical nursing work, with the largest practice group

being medical/surgical and intensive care nurses (24%), followed by midwives (15%), emergency department nurses (7%), paediatric nurses (4%) and other practice groups (44%). A small group were from fields considered to have a 'specialist' focus, namely, drug and alcohol and mental health (6%). The study sample was found to be representative of the ACT nurse population and few differences were found between responders and non-responders (see Ford and Bammer 2009).

### Variable for analysis

The eight page questionnaire used in the main study contained 40 questions. The questionnaire was pre-tested in four stages and piloted with 82 participants to ensure face and construct validity.

A variable taken from the National Drug Strategy Household Survey (NDSHS) was used to examine nurses' views on a range of measures for problems associated with illicit drug use. The NDSHS is based on households and information, collected via computer assisted telephone interview, drop and collect self-complete questionnaire and face-to-face interview. The survey was completed by 26,744 Australians aged 14 years and over (AIHW 2002). The variable was thus considered a valid means of measuring nurses' views, and the raw data held in the NDSHS database could be used for comparison purposes with this study's data.

The variable for analysis 'Views on a range of measures for problems associated with illicit drug

use', was scored on 6-point Likert scale: 1 – strongly support, 5 – strongly oppose, and 6 – *don't know enough to say* (thus a higher score showed more opposition for the measure). While the *don't know enough to say* data are presented in this paper, they were not included in the analysis.

### Statistical methods

The statistical analysis was performed using STATA software (version intercooled (8.2) (STATACorp 2003). Parametric statistics (t-test, Spearman rank order correlation, Chi-square test and ANOVA) were used for descriptive and inferential purposes. To minimise type 1 errors (resulting from multiple testing), a significance level of <0.01 was used. The summary scores, an analysis of nurses' views about harm reduction measures and other treatments, and a comparison between nurses' views and those of the Australian population are presented below.

### FINDINGS

#### Nurses' views on measures for problems associated with illicit drug use

The seven items in this variable are displayed in table 1 in the same order as they appeared in the NDSHS (AIHW 2002). One item was deleted from further analysis: 'treatment with drugs other than methadone' was affected by a high percentage of *don't know enough to say* responses (27%) and missing responses (2%). In total, 470 nurses did not express an opinion on this measure.

**Table 1: Nurses' views on a range of measures for the problems associated with illicit drug use (n, % in brackets, n = 1,605)**

	Strongly support	Support	Neither support/oppose	Oppose	Strongly oppose	Don't know enough to say	Missing
Regulated injection rooms	336 (21)	535 (33)	137 (8)	233 (15)	265 (17)	70 (4)	29 (2)
Trial of prescribed heroin	260 (16)	488 (30)	159 (10)	268 (17)	292 (18)	107 (7)	31 (2)
Rapid detoxification therapy	347 (22)	627 (39)	181 (11)	70 (4)	34 (2)	322 (20)	24 (2)
Use of naltrexone	368 (23)	713 (44)	160 (10)	44 (3)	28 (2)	269 (17)	23 (1)
Needle and syringe program	571 (35)	644 (40)	121 (8)	101 (6)	95 (6)	44 (2)	29 (2)
Methadone maintenance program	299 (19)	708 (44)	231 (14)	157 (10)	92 (6)	86 (5)	32 (2)
Treatment with drugs other than methadone	255 (16)	541 (34)	239 (15)	60 (4)	40 (2)	443 (27)	27 (2)

Attitude scores are negatively coded: 1 strongly support to 5 strongly oppose

Of the remaining six items, it can be seen that a substantial percentage of nurses did not express an opinion on two: 'rapid detoxification therapy' (20%) and 'use of naltrexone' (17%). This level of *don't know enough to say* responses caused a problem for interpreting nurses' preferences. Therefore, the *don't know enough to say* and *missing responses* ( $n = 559$ ) were removed so that the analysis was conducted only on respondents who expressed an opinion on all measures ( $n = 1,046$ ). Nurses' preferences were evaluated from the most popular to the least, and significant differences between their choices were identified.

Table 2 shows nurses' preferences from the most popular to the least popular - the mean score, standard deviation of the mean and the percentage of nurses who *strongly supported* or *supported* each measure are provided. A high level of support for abstinence-based measures (use of naltrexone for the maintenance of abstinence and rapid detoxification therapy) is evident. There is no statistical difference in nurses' support for the use of naltrexone (82%), rapid detoxification therapy (77%) or the harm reduction measure, the needle and syringe programs (76%).

However, nurses reported significantly more support for the relatively new measures, the use of naltrexone ( $t = 10.95, p \leq .001$ ) and rapid detoxification therapy ( $t = 8.24, p \leq .001$ ), than the long-established methadone maintenance program. They were also significantly more supportive of the needle and syringe program than the methadone maintenance program (66%) ( $t = 11.84, p \leq .001$ ). Regulated injection rooms (58%) and prescribed heroin (52%) gained least support.

Nurses' responses to these measures showed a particular pattern. In table 3 the Spearman's rank-order correlation ( $\rho$ ), shows strong correlation between attitudes to the two abstinence measures, rapid detoxification therapy and use of naltrexone ( $\rho = 0.66$ ). Strong correlations were also found between attitudes to the four harm reduction measures ( $\rho = 0.45$  to  $0.75$ ). Weak correlations existed between harm reduction measures, and abstinence-based measures ( $\rho = 0.11$  to  $0.26$ ), suggesting that nurses held either an abstinence-based or a harm reduction ideology.

**Table 2: Nurses' views on a range of measures for problems associated with illicit drug use ( $n = 1,046$ : nurses who expressed an opinion on all measures)**

	Mean (SD)	Support or strong support (%)
Use of naltrexone	2.0 (0.9)	82
Rapid detoxification therapy	2.1 (0.9)	77
Needle and syringe program	2.0 (1.1)	76
Methadone maintenance program	2.4 (1.2)	66
Regulated injection rooms	2.7 (1.4)	58
Trial of prescribed heroin	2.9 (1.4)	52

Attitude scores are negatively coded: 1 strongly support to 5 strongly oppose

**Table 3: Nurses' attitudes to abstinence (*italics*) and harm reduction measures (**bold**): Spearman rank-order correlations showing the size of the relationship between measures**

	1	2	3	4	5	6
<i>Use of naltrexone</i>	1.00					
<i>Rapid detoxification therapy</i>	.66	1.00				
<b>Needle and syringe program</b>	.26	.18	1.00			
<b>Methadone program</b>	.26	.17	.51	1.00		
<b>Regulated injecting rooms</b>	.19	.11	.60	.46	1.00	
<b>Trial of prescribed heroin</b>	.20	.14	.52	.45	.75	1.00



### Comparison with the population

Nurses' views were compared with those of the general population via the raw data held in the NDSHS database (AIHW 2002). The age spread of the population was restricted to 21 to 72 years to match the nurse sample. Most of the nurses were women (94%), therefore data from women in both samples who *expressed an opinion on all measures* was used in the analysis (nurse sample  $n = 1,046$ ; population  $n = 6,441$ ).

The female nurse sample was compared with the female population using the one-way analysis of variance (ANOVA), a test that compares pairs of means. Table 4 shows the mean score, the standard deviation of the mean, and the  $f$  statistic and  $p$  value from the one-way ANOVA tests.

Female nurses and women in the population reported the same high level of support for the use of naltrexone for the maintenance of abstinence. There was no statistical difference between the samples. Both also supported rapid detoxification therapy but the female nurses were significantly less supportive than women in the population.

Female nurses were significantly more supportive of two harm reduction measures than women in the population - the needle and syringe program and the trial of prescribed heroin. Female nurses reversed this trend however, by being significantly less supportive of the methadone maintenance program than women in the population. Finally, female nurses and women in the population were not different in their low support for regulated injecting rooms.

**Table 4: Comparison of the female nurse sample and the female population for measures used for the problems associated with illicit drug use (means, SD)**

	Nurse sample $n = 1,046$	Population $n = 6,441$	$f$	$p$
Use of naltrexone	2.0 (0.9)	2.0 (1.1)	0.01	= .90
Rapid detoxification therapy	2.1 (0.9)	1.8 (1.0)	38.51	≤ .001
Needle and syringe program	2.0 (1.1)	2.4 (1.4)	50.14	≤ .001
Methadone program	2.4 (1.2)	2.3 (1.2)	6.90	≤ .01
Regulated injecting rooms	2.7 (1.4)	2.8 (1.5)	1.72	= .19
Trial of prescribed heroin	2.9 (1.4)	3.1 (1.5)	10.41	≤ .001

Attitude scores are negatively coded: 1 strongly support to 5 strongly oppose

### Relevance to nursing practice

Nurses in this study supported the needle and syringe program and, like the Australian population, preferred abstinence-based measures over the methadone maintenance program, regulated injection rooms and prescribed heroin. The differences between the nurse sample and the Australian population showed some statistical significance, the most interesting being nurses' lower support for the methadone maintenance program. However, no clear trends were evident in these differences, and were of minimal real importance.

The controversy over methadone, according to Sees et al (2000), possibly rests on the fact that it is a 'dependence-producing medication' (p.1303).

However, it is essential that nurses look beyond such controversies and inform themselves about the aims of harm reduction treatments. The nursing workforce is large and has many and varied points of contact with this patient group. Nurses are well-positioned to play a role in helping to reduce the harms associated with illicit drug use.

Some nurses in this study demonstrated their lack of knowledge of drug treatments with approximately 35% of the study sample ( $n = 559$ ) either failing to provide a response, or choosing the *don't know enough to say* option, on at least one of the six treatments. The study sample is representative of the full spread of nursing specialties; therefore it might be reasonable to expect a lack of knowledge from some

nurses. However, illicit drugs are a major public health concern in Australia, and nurses in almost all fields of nursing are involved in the care of patients who use them. An evidence base should inform nurses' professional practice with this patient group, just as it does with other patient groups. Small et al (2008) provide examples of how nurses in a safe injecting facility provided harm reduction interventions to patients, namely, referral to appropriate health and drug treatment services, education about safer injection practices and assessment and treatment of infectious complications. Wood et al (2008) also found that nurses' care assisted IDUs to minimise harms associated with injecting practices, while Krüsi et al (2009) found nurses' care to improve IDUs' uptake of health care.

An abstinence-based ideology fails to recognise that illicit drug dependence is a chronic disease that is influenced by genetic makeup and in which pathophysiological changes occur (McLellan et al 2000). Thus drug use problems are not acute problems with immediate and lasting solutions, but chronic problems with a requirement for on-going care. Once an individual has reached the stage of dependence they can enter a spiral – dependent use, followed by abstinence, followed by lapse to use, followed by abstinence. It is important that nurses understand the harms that non-abstinent individuals experience in the event that abstinence is the only option provided to them. Nations that prioritise a drug-free society (and therefore prohibit methadone maintenance and needle and syringe programs) have been found to have a high rate of blood borne disease, a high proportion of HIV disease in IDUs, a high rate of risky drug use practice – all without a reduction in drug use (Aceijus et al 2004; Reid et al 2007; Bravo et al 2007). In those nations and cities where sterile needles and syringes are prohibited, active policing causes IDUs to engage in rushed, risky injecting practices, syringe sharing and unsafe equipment disposal (Aitken et al 2002).

Harm reduction measures improve the health and well-being of individuals who use illicit drugs. As inpatients in hospital wards and departments,

individuals will benefit greatly from their interactions with nurses if these nurses understand and value harm reduction measures. In addition, an informed nursing workforce will go some way towards informing the public about the efficacy and effectiveness of both harm reduction and abstinence-based measures, based on the evidence. Without knowledge of the evidence base, nurses risk denying their patients appropriate care and also perpetuating the myths commonly held by the general public.

## DISCUSSION

The aim of this study was to gather evidence on how registered nurses in Australia view treatments for illicit drugs, as an essential first step in workforce development. This study provides evidence that registered nurses closely match the views of the Australian public in their preferences for illicit drug treatments. Like the Australian population, nurses were misguided in their optimism about untested abstinence-based measures (approximately 80% support) and their scepticism about proven harm reduction measures, particularly the methadone maintenance program (66% support).

Illicit drug use behaviour is interpreted in different ways by individuals in society. Those people who view drug use as wilful misconduct see the solution as belonging primarily in the criminal justice domain, while others see medical treatment (drug use as an illness) or forced abstinence (drug use as moral failing) as the answer (Wild et al 2001). It is possible, but not proven in this study, that nurses form their views in the same way that the Australian population does, namely, through the mass media and other informal channels. In the years leading up to data collection, claims were made in the popular press about the usefulness of abstinence-based treatments (Elliot and Chapman 2000) with ambivalence or opposition reported for supervised injecting facilities and the trial of prescribed heroin (Mendes 2002). From the perspective of nursing care provision, however, patients who use illicit drugs are entitled to high quality care that is based on the best available research evidence. The challenge for nursing is to



educate and upskill nurses so that they are able to offer nursing interventions, advice, and referral that will maximise IDU's health outcomes.

Twenty-five years ago, of the entire Australian health workforce, nurses were singled out as the largest professional group involved in the treatment and management of drug-related problems. The importance of the role of the registered nurse was highlighted in a report by the Task Force for the Training Requirements of Professionals and Non-professionals in the Alcohol and Drug Field (Ministerial Council on Drug Strategy 1986). It recommended the establishment of a national minimal standard of basic training.

A decade after these recommendations were published, a review of drug and alcohol education for frontline workers found education for nurses to be poor in terms of its 'delivery, quality and content' (Allsop et al 1998 p.25). It was found that, if drug and alcohol subjects existed in undergraduate nurse curricula, they were generally offered as elective (rather than core) subjects, and the volume and quality of the education rested on the initiative of individual nurse academics with an interest in the field (Allsop et al 1998; Siggins Millar Consultants 2003). Recently published results from this current study (Ford et al 2008; 2009) show that pre-service drug and alcohol education for nurses in the ACT is a scarce resource, with one-third of the study sample reporting no pre-service education and a further one-third reporting less than five hours. It can be said that drug and alcohol education continues to have a low priority and remains vulnerable in the undergraduate nursing curriculum.

Workplace drug and alcohol education for practicing nurses is also limited. A study of critical care nurses in Melbourne metropolitan hospitals ( $n = 89$ ) found that over half the study sample did not know the signs of intoxication or side effects of common illicit drugs such as amphetamine, cocaine, ecstasy and heroin (Brotto 2005). Most study participants (85%) agreed that they needed education on how illicit drugs affected critically ill patients. Our study (Ford et al 2008, 2009) found workplace education to be

limited, with 34% reporting no education, a further 32% reporting less than five hours and only 22% reporting education in the preceding 12 months.

Nurses need education on the evidence for illicit drug treatments; they need to be able to clearly articulate the costs and benefits associated with various harm reduction and abstinence-based treatments. Recent calls have been made for undergraduate and postgraduate education supported by clinical placement in the field (Lovi and Barr 2009) and workplace education and support (Ford 2008, 2009). The findings of this study add weight to this call for education.

### **Strengths and limitations of the study**

This study appears to be the first to evaluate nurses' views on harm reduction measures and other treatments for the problems associated with illicit drug use. The approach used allowed an analysis of the views of the total population of nurses in the ACT and a comparison between these nurses and the Australian population.

A limitation of a cross-sectional study is that it provides a snapshot of attitudes at a specific time, and this may rapidly cease to represent reality. The data for this study was collected in 2003, however, the issue under study, nurses' attitudes to illicit drugs management, is unlikely to undergo a rapid change given that community attitudes and values are very slow to change and particularly when nurses' pre-service and workplace illicit drugs education remains limited. The study has provided important insights into nurses' views and this knowledge can now be used to guide professional development.

A second limitation of a cross-sectional survey is that it may leave the study open to bias from an unrepresentative sample. In this case however, the study sample was found to be representative of the ACT nurse population and few differences were found between responders and non-responders (see Ford and Bammer 2009). It is not clear that these results can be extrapolated beyond the ACT, but there is no reason to expect differences in nurse characteristics in other states and territories in Australia: the nursing

workforce is homogenous in terms of most available demographic characteristics (female, middle class, mainly university educated), nursing education is based on national standards that aim to engender a common worldview, and nursing practice is governed by a national code of ethics.

## CONCLUSION

Given their high exposure to patients who use illicit drugs, registered nurses are in an ideal position to offer appropriately targeted nursing interventions, drug treatment advice and referral to this marginalised patient group. A large majority of nurses in this study (approximately 80%) were mistakenly optimistic about abstinence-based measures. One harm reduction measure, the needle and syringe program was also well supported by nurses (76%), however, there was significantly lower support for the methadone maintenance program (66%), regulated injection rooms (58%) and prescribed heroin (52%). Nurses mirrored the Australian population's attitudes of high support for abstinence-based measures for the problems associated with illicit drug use. The study calls for pre-service and workplace education for nurses so that they can understand and articulate the evidence for harm reduction and abstinence-based treatments. The nursing workforce is large and has many and varied points of contact with this patient group, nurses are well-positioned to play a role in helping to reduce the harms associated with illicit drug use. An evidence base must inform nurses' professional practice with this patient group.

## RECOMMENDATIONS

Targeted education on the scientific evidence of the efficacy and effectiveness of various illicit drug treatments is recommended.

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# Models of health service delivery in remote or isolated areas of Queensland: a multiple case study

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## KEY WORDS

Health Care; Hospitals; Nurses; Primary; Remote Consultation; Rural; Rural Health Services

## ABSTRACT

### Objective

This paper reports on models of health service delivery in remote or isolated areas of Queensland.

### Background

There is little research that investigates current models of health service delivery in remote or isolated areas of Australia.

### Design

A multiple case study research design was employed that included interviews and focus groups.

### Setting

Three types of health care facilities in remote or isolated Queensland.

### Subjects

Thirty five registered nurses.

### Results

Findings indicated that nurses and Indigenous health workers are predominantly resident and provide health services in this environment, while medical and allied health care services are usually provided by non-resident visiting specialists.

### Conclusions

Findings suggest that meeting the needs of communities in remote and isolated areas of Queensland requires a change in the focus of health service delivery to accommodate a primary health care philosophy. The introduction of a new model of health service delivery is recommended; however this will only occur if resources are harnessed to prepare staff to reprioritise services offered.

### Implications for Health Service Management

Supporting community partnerships with shared responsibility between health service providers and community members for increasing primary care prevention practices is advocated.



## INTRODUCTION

The delivery of health services in isolated and remote areas of Queensland is an ongoing concern for the Queensland Government. These geographical areas are characterised by small populations spread over vast distances with a significant proportion of Aboriginal and Torres Strait Islanders compared with national averages (ABS 2006 Wakerman et al 2006). A need to understand current models of health service delivery prompted this study. This paper reports on models of health service delivery in remote and isolated areas of Queensland and is part of a larger study into the role of nurses working in these locations. The three models of care identified are described and illustrated using a multiple case study design. Findings are discussed in the context of the contemporary literature regarding models of primary health care delivery in rural and remote areas.

## BACKGROUND

Australian nurses have a long history of providing health care for communities in remote and isolated locations. These locations are naturally very diverse, both geographically and contextually, and the models of health service delivery utilised are adapted to meet local community needs. Many nurses in remote and isolated Queensland provide primary care, as they are the first point of contact with the health care system. Primary care services include both prevention and early intervention activities such as immunisation, health screening, family planning and treatment for non-threatening conditions such as coughs, colds and localised infections. If required, nurses working in remote or isolated areas refer clients to other health care providers for the provision of secondary level care such as confirmation or early detection of disease, and/or therapeutic intervention/treatment of a problem. The third classification of health care, tertiary care, usually involves long term treatment for disease or events that have resulted in physiological damage (Timby 2008) and is a large part of these nurses' role (CRANA 2008; DHCS 2008). At this juncture it is important to highlight the difference

between primary care and primary health care. Primary health care has a more comprehensive brief than primary care, and incorporates universal access to resources, disease prevention and health promotion, community and individual engagement in self care, intersectorial approaches to health, and cost effective solutions to promoting wellbeing that incorporate all aspects of an individual's life and environment (Felix-Bortolotti 2009).

Interprofessional teams of health care workers servicing remote or isolated areas of Queensland are either resident (i.e. living in or near to the community in which they work), or non-resident (i.e. live away from the community). Team members include doctors, nurses and allied health professionals, e.g. physiotherapists, speech therapists and occupational therapists. Non-resident teams work alongside resident team members, providing specialist services in communities too small to support permanent services (Wakerman et al 2006). Non-resident teams tend to 'fly-in/fly-out', and in Queensland these services are primarily provided by the Royal Flying Doctor Service (RFDS) and Queensland Health. Service provision by these organisations can be regular (e.g. general health checks, dental clinics, chronic disease screening and management), emergency care or patient transfer.

A basic assumption of this study was that models of health service delivery and models of care are inextricably linked. Our construct of models of health service delivery is that they are formulated from an assessment of community need, current infrastructure, staffing mix, delivery modes, policy and resources. The practice of staff working in health care teams defines the models of care provided within the service. How activities are prioritised, labour is divided, staff are rostered, supportive relationships are developed, information is communicated, as well as the levels of knowledge and skills of individuals, influences the way in which health care professionals practice in providing care both individually and as part of a team. The configuration of models of health service delivery can either enhance or detract from the implicit model of care delivered and the

functioning of staff who practice within it. Key to developing contemporary models of care is the translation of policy and evidence into the practice of health services.

## METHODS

The research described here is part of a broader investigation into the role of the registered nurse working in remote or isolated regions of Queensland (Mills et al 2008a). Queensland Health commissioned the research and approval was secured from the ethics committee of the researchers' employing university prior to commencement of the study.

Thirty-five registered nurses participated in this study, which utilised a combination of individual interviews (23) and focus groups (4) for the purpose of data collection. A multiple case study design was employed to examine the role of these nurses who worked in diverse geographical locations of South West Queensland, Central and Central West Queensland, Townsville and Mt Isa, Cape York Peninsula and the Torres Strait Islands. Multiple case study design permits identification of similarities and differences between and amongst cases, both individually and as a combined entity (Stake 2006). In examining the models of health service delivery employed by nurses working in remote and isolated areas of Queensland, three cases were identified in the planning stage of the study:

1. Case One – Primary health care clinics in Indigenous communities
2. Case Two – Primary health care clinics with overnight bed capacity in Indigenous communities, and;
3. Case Three – Outpatients clinics/small acute services in non-Indigenous communities.

Data generated with participants during the interview process was analysed and initial themes constructed using a team approach. The initial themes were reviewed by an expert panel and refined through subsequent analysis. The results of this process provided an overview of the models of health service delivery utilised by registered nurses working in remote and isolated areas of Queensland.

## FINDINGS

Participants in this study identified three models of health service delivery currently operating in remote or isolated areas of Queensland:

1. Torres Strait Islands Model of Primary Health Care
2. Enhanced Model of Primary Health Care
3. Interventionist Model of Secondary Health Care

Participants in Case One and Two facilities used a combination of either the Torres Strait Islands Model of Primary Health Care or the Enhanced Model of Primary Health Care and the Interventionist Model of Secondary Health Care, while participants in Case Three facilities used the Interventionist Model of Secondary Health Care almost exclusively.

### Torres Strait Islands Model of Primary Health Care

Indigenous communities in the Torres Strait Islands appeared to have much more control over and input into models of health service delivery in their local environment. A Case One participant summarised the division of labour in these primary health care teams as consisting of an:

*Indigenous Manager, then Indigenous Health Workers and the RN on the bottom.*

*In this model of health service delivery the role of the registered nurse is one of coach and resource for the primary health care team – providing knowledge and skills that can be accessed in times of doubt or need.*

*You're like the hub of the wheel supporting all the spokes that go out to the people.*

For nurses working in the Torres Strait Islands Model of Primary Health Care, a condition of their employment is the provision of a 24/7 on-call emergency response service. For Case One participants employed under such an arrangement, hours of work were focused around this on-call requirement. Being on-call was identified as a major stressor for these participants who believed they were viewed as being available on-call even when off duty. In theory the on-call roster is shared amongst the resident team, however the registered nurse is often called out because of their role as a resource person.

Not all participants working within the Torres Strait Islands Model of Primary Health Care considered this model to be working as well as it could. This was particularly the case in relation to a perceived need to provide more primary health care as opposed to primary care. One Case One participant stated that:

*[The model's] not primary health care, it's primary care and very biomedical, focused on screening, not much follow up, virtually no health promotion and not much prevention.*

The efficiency of the Torres Strait Islands Model of Primary Health Care in addressing the primary health care needs of the community appeared to relate to how well the registered nurse was able to develop preventative health care strategies. One participant stated:

*The number of call-ins that you get... is a pretty good indicator of the overall health and wellbeing of the community, so you go to a place that's got a really good primary health care program and people's chronic diseases are well managed, you're only getting called out for those incidental acute sort of things that come up. Generally people with well-managed chronic diseases tend to have more insight into their health problems... so they're more likely to manage smaller things at home and come and see you in business hours.*

Another key issue identified for the Torres Strait Islands Model of Primary Health Care was the number of Papua New Guinean Nationals who crossed the border to access health services. This invisible demand placed on limited resources created significant pressure on a model of health service delivery that is essentially only designed to meet the needs of a small local Torres Strait Islander community.

*Most of the resources and medications go across the border [to PNG] so you're not doing anything for the community which you're operating in... It's necessary because any public health concerns they have over there are public health concerns here too.*

The Torres Strait Islands Model of Primary Health Care appears to have had mixed success in implementation. Transition of the registered nurse from their traditional role as manager, to being managed, influences the effectiveness of the model of service delivery in operation. One Case One participant said:

*More primary health care is more effective than just responding to acute episodes. This model will work if people will let it, [however it] needs good managers with good management skills.*

Generally speaking, however, participants in Case One felt that to date the implementation of the Torres Strait Islands Model of Primary Health Care with its emphasis on community assessment, input and control had resulted in more positive health outcomes for the community.

*I think the model of care, it's not operating as well as it could be, but it's more conducive to actually getting things done and it's actually improving people's health outcomes, [more so] than what I'm normally used to.*

### **Enhanced Model of Primary Health Care**

Case One participants identified the Enhanced Model of Primary Health Care in Indigenous communities as one that prioritised preventative health promotion and education. However, all Case One participants working in Indigenous communities spoke of their actual model of service delivery and care as being a combination of primary, secondary and tertiary approaches underpinned by an Interventionist Model of Secondary Health Care. As one participant put it, registered nurses in Case One currently provide a 'Bandaaid service' to local communities.

*The enhanced model of primary health care is the one we are trying to push for the communities – you're never going to do away with acute care services though, it needs to be here – I wonder sometimes if it will split where we have these [currently] visiting teams who provide chronic disease management and prevention [on a] permanent [basis] in the communities – where registered nurses are providing acute care services out of the clinic but attached to the clinic is a primary prevention health care model.*



The advent of visiting specialist health professional teams has impacted on how Case One and Two participants viewed primary health care and their role within the broader health care team. Participants voiced a belief that while enhancing primary care was important it was somebody else's responsibility. The business of local registered nurses was to provide primary and secondary care to community members while also managing the administrative and liaison work of the centre. Participants regarded the provision of primary care as both a burden and an obstacle to being able to manage their time and workload. Concomitantly, there was recognition that as a resident health care professional, the registered nurse was more in tune with the local community and better placed to actually do this work than the visiting non-residential teams.

*What has taken some of the burden of the prevention and promotion of health away from us, is our visiting teams. We have good support and they have that as part of their role. They are starting to run programs in the community and that's relieved us I guess, though [that is] not necessarily a good thing because they tend not to get so involved.*

Within the Enhanced Model of Primary Health Care discussed by Case One and Two participants, a strategy called 'house health promotion' was identified. This involved Indigenous health workers visiting people in their homes to conduct screening, one-on-one health promotion and education. Target areas for house health promotion were smoking, alcohol and other drug use, exercise and nutrition. Case One participants in the Torres Strait Islands Model of Primary Health Care gave similar examples of house health promotion. This Case One participant however, spoke of how living and also working in an Indigenous community can be a barrier to undertaking primary health care activities:

*I think it's how you're perceived by the community that's going to have an impact on the sorts of activities you can provide that will work – they'll say 'when is that ATOD's [Alcohol, Tobacco and Other Drugs] man coming?'... It*

*seems that visiting people can provide a different service, people may feel more comfortable about disclosing to a stranger than they do to somebody they see in the store, walking on the beach, that they see when they come in to the clinic.*

Findings generated with participants in Case One and Two suggest that the Enhanced Model of Primary Health Care is perceived as being something distinct from, or to be employed in addition to, a traditional Interventionist Model of Secondary Health Care. In Case Two, implementing a model of health service delivery that is supported by the tenets of primary health care does not appear to be as strongly driven by the community as it was in Case One facilities in the Torres Strait Islands.

### **Interventionist Model of Secondary Health Care**

An Interventionist Model of Secondary Health Care was clearly the predominant model of health service delivery in Case Three and to a great extent in Case One and Two facilities in Aboriginal communities. There was less evidence that this was so in Case One facilities in the Torres Strait Islands. Resistance was noted however from some participants reluctant to transition to the Torres Strait Island Model of Primary Health Care, as the traditional division of labour is reconfigured to remove the registered nurse from the top of the hierarchy of power.

*The greatest hurdle for many RANs [in adapting to the Torres Strait Islands Model of Care] is that they are not in a management role.*

Closely aligned with a traditional bio-medical model of care, the Interventionist Model of Secondary Health Care considers the health professional to be an expert, providing interventions to meet the needs of individuals with emergent and potentially life-threatening (secondary) or chronic (tertiary) conditions. In remote or isolated areas of Queensland registered nurses are usually the first point of contact for patients and clients, as compared with metropolitan areas of Australia where the general practitioner is usually the first point of contact. The main difference between the Interventionist Model of Secondary Health Care, and the two models presented previously, is the prevailing philosophy.

Rather than working 'with' a community, in an Interventionist Model of Secondary Health Care, health professionals work 'on' a community. Implicit in this approach is that instead of providing a proactive service aimed at meeting identified community needs, health professionals are reactive to individual clients' health care crises.

In Case Three, participants strongly identified with the philosophy of the Interventionist Model of Secondary Health Care. Key to this identification was the notion that registered nurses substituted for the general practitioner as initial care providers in their communities. This was particularly the case for participants whose registration was endorsed for rural or isolated practice.

*Rural and isolated practice endorsed nurses can supply antibiotics and other medications and now that people know that, they come here rather than going into town, to the hospital or GP [general practitioner].*

*Because I can give people antibiotics, that's what I spend half the day doing.*

## DISCUSSION

Three distinct models of health service delivery are currently in operation in remote or isolated areas of Queensland. They share some similarities but are notably different in staffing mix, community context and leadership. These models are the Torres Strait Islands Model of Primary Health Care, the Enhanced Model of Primary Health Care and the Interventionist Model of Secondary Health Care.

Participants in this study suggested that the Torres Strait Islands Model of Primary Health Care allows for more community control and input in the operation of the service than the other models. Community participation in health care can improve sustainable health outcomes for individuals, families and the community (Kim-Godwin et al 2001; Church et al 2002), and can develop environments that encourage healthy living (Hoodless et al 2008).

In areas where the Torres Strait Islands Model of Primary Health Care is used, the health care team usually comprises a registered nurse and one or

more Indigenous health workers. There is usually an Indigenous health service manager employed on the team, who leads the operation of the service. Indigenous health workers are the first point of contact for community members and undertake the bulk of hands-on work, while the registered nurse supports the team, both coaching and guiding them in their practice as well as acting as a clinical resource person.

Services in all of the models of care are provided around the clock with team members rotating through the on call roster. In reality however, the registered nurse often attends emergencies as they are always either the first or second person on call and are often required to provide clinical expertise in support of other team members. Similar findings have been reported by both Weymouth et al (2007) where nurses report being on call for extended periods of time, and Yuginovich and Hinspeter (2007), where one nurse reported being on call for 100 days with no break. It has been suggested that nurses in small remote or isolated communities are effectively on call 24 hours a day, seven days a week, irrespective of rosters (Hanna 2001; Cramer 2006) and that this constitutes a major source of stress in this group of nurses (Lenthall et al 2009).

Participants suggested that the provision of effective primary health care to a community is reflected in the number of emergency call-outs recorded. Two key factors were identified that can influence the amount of afterhours work. Firstly, where the level of primary health care provided is high, the community tends to self-manage chronic disease after hours. D'Souza et al (1998) found that patients who received an asthma self-management plan were less likely to need emergency visits to general practitioners, attendance at hospital emergency departments and hospital admission compared with those who received standard care. In patients with chronic obstructive pulmonary disease similar results were reported (Bourbeau et al 2003). Secondly, effective communication between nurses and the community about what constitutes an afterhours emergency can further reduce after hours work. Strategies have been described in the literature to assist nurses in

educating patients to determine whether their illness is an emergency, and how to contact emergency services (DHF 2008).

Lessons from the Torres Strait Island Model were that the ability to provide effective primary health care is dependent on the capacity of the resident health care team, with non-resident specialist teams visiting to provide specific services. Success relies on: the successful transition of the role of the registered nurse from one of manager to one of coach and guide; the competency and skill level of the Indigenous health workers and the abilities and skills of the Indigenous health service manager.

Genat (2006) believes that the practice of Indigenous health workers should be the primary vehicle through which health care is delivered in Indigenous communities. He suggests that the knowledge of Indigenous health workers is undervalued and a change in organisational structure is required in order to recognise this specialist knowledge. Indigenous leadership of health care services would facilitate a more client centered, holistic and culturally safe service (Genat 2006; Eckermann et al 2006). In addition, Wilson and Grant (2008) remind us that it is the recipient who determines whether the service and care provided is culturally safe, not the provider of the service. In this study, the Torres Straits Model of Primary Health Care was found to closely align with this philosophy of care.

The Enhanced Model of Primary Health Care, whilst espousing the ideals of preventative health promotion and education is in reality more of Band-aid service, with a mix of primary, secondary and tertiary health care provided by health care teams. The role of the registered nurse in this model is to lead health care teams while providing mostly secondary level care. These nurses liaise with local primary health care centres and manage administrative work. Both Yuginovich and Hinspeter (2007) and Hanna (2001), argue that remote area nurses are limited in their ability to provide primary health care by a lack of time and support. This is demonstrated in the Enhanced Model of Primary Health Care where it falls to Indigenous health workers to carry out home visits for the purposes of screening and health

promotion. In some ways, this activity of Indigenous health workers is supported by the previous argument proffered by Genat (2006), however the Enhanced Model of Primary Health Care does not include Indigenous health managers in health care teams, rather, the registered nurse assumes this leadership position, delegating primary health care activities to Indigenous health workers.

The delivery of primary health care was recognised by participants working in the Enhanced Model of Primary Health Care as important, but became a lower priority when their workload became too difficult to manage, a finding supported in the literature by Hanna (2001). In this scenario, registered nurses view the provision of primary health care as a burden and an obstacle to providing what is considered higher priority health care. Whilst recognising that the registered nurse is well placed to provide primary health care, participants working within the Enhanced Model of Primary Care saw it as someone else's responsibility. This attitude was tied to the influx of non-resident members of the team who flew in to undertake health promotion and chronic disease management activities. Being a member of the same community was also seen as a barrier to planning and implementing primary health care activities, because of the identity the registered nurse has within the community. For nurses living in rural, remote or isolated areas of Australia, having multiple senses of self can sometimes lead to role conflict (Mills et al 2008b).

The Interventionist Model of Secondary Health Care positions health professionals as the experts. In remote or isolated areas of Queensland, this means the registered nurse is usually at the top of the hierarchy of power. Such an arrangement reflects the traditional bio-medical model of health care (Germov 2009) where interventions are provided to meet the secondary (acute and potentially life threatening presentations) and tertiary (chronic) needs of individuals. This model clearly has the most limitations for communities in remote and isolated areas in which the participants in this study were employed.

Primary health care in its purest form is a broad concept that addresses all social, environmental and lifestyle determinates of health (Felix-Bortolotti 2009). Findings from this study indicate that there is great variation in the models of health service delivery across the sites in which nurses are employed in remote or isolated areas of Queensland. Even though many participants were aware of evidence about the effectiveness of preventative health care education and activities in reducing the burden of secondary and tertiary conditions, much of the nurses' energy in their role was directed towards interventionist management of chronic disease and acute presentations. The need for nurses working in remote or isolated areas of Australia to prioritise emergent cases has been identified in the literature as a barrier to implementing a primary health approach to care (Yuginovich and Hinspeter 2007; Hanna 2001).

Overall, models of health service delivery used throughout remote and isolated Queensland demonstrate a process in which local (resident) and visiting (non-resident) health care professionals largely act upon, rather than with, the community. This is similar to the bio-medical model of health care (Germov 2009). Nurses may be seen as a substitute for a general practitioner, with little input from the community or individuals in the decision making process. Their work is viewed as a series of tasks and activities rather than being driven from a particular theoretical position, focusing on addressing specific clinical issues rather than a wider view of prevention and the social and emotional wellbeing of their clients. Registered nurses working in biomedical models of health care often consider their care to be very holistic because, as members of the community, they feel they have a greater insight into the background of the individual community members. However, it has been suggested that without input and involvement from the community, they are unlikely to gain much insight or understanding of the background of their clients – rather their understandings are drawn from their own observations, rather than from interaction and dialogue (Genat 2006; Eckermann et al 2006; McMurray 2003).

## RECOMMENDATIONS

Findings from this study support the development of a new model of health service delivery in remote or isolated areas of Queensland with a greater emphasis on primary health care. Implicit in planning for such a change is consideration of the contextual elements impacting on individual communities that need to be assessed and incorporated into a population based primary health care framework. Many of the participants of this study demonstrated an awareness of the importance of working with factors inherent in the socio-cultural, economic and political environment to ensure relevance and effectiveness of care delivery. In a number of instances, the efforts of the health care professionals go some way to achieving this goal, yet this is neither a consistent nor universal outcome for clients.

This study recommends a model of health service delivery that includes resident health service providers (including nurses, medical officers, Indigenous health workers and managers) working in conjunction with non-resident service providers (such as visiting specialist teams and locum staff), to provide care at primary, secondary and tertiary levels within a primary health care framework (Figure 1).

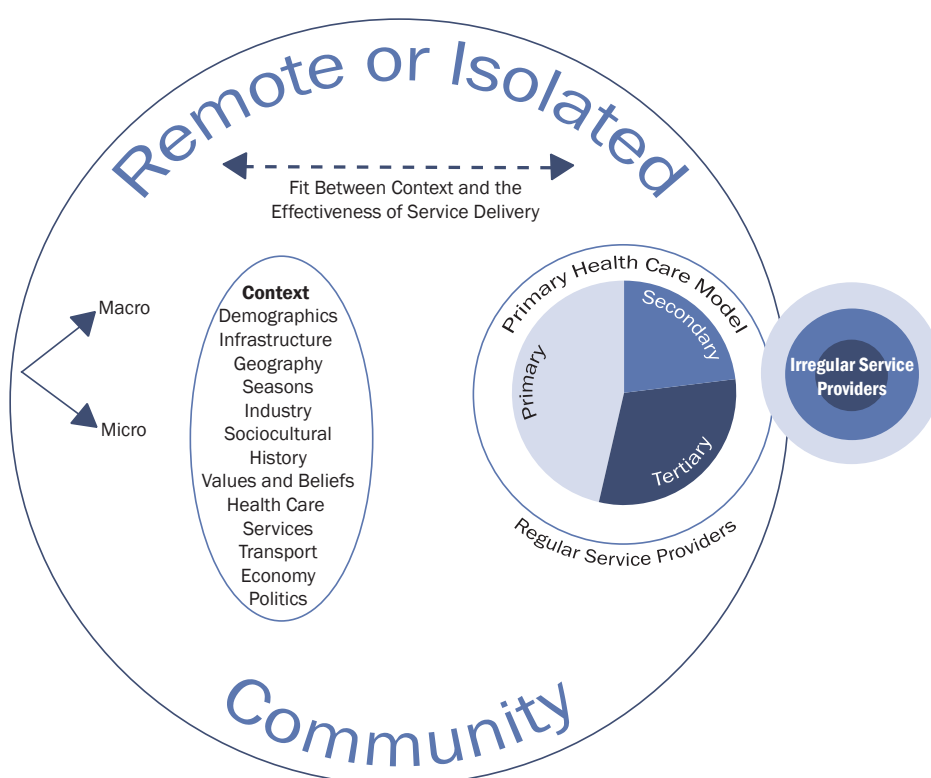
In this model, an increased emphasis on primary health care is reflected in the balance of time devoted by the health care professionals to preventative versus emergent or restorative care activities. The model capitalises on findings from this study that demonstrate greater success in health care provision when elements within both the micro and macro environment are incorporated into health service delivery processes. The study identified a number of examples where nurses working with Aboriginal or Torres Strait Islander communities using a primary health care approach demonstrated an increase in the effectiveness of health services. A thorough understanding of local contextual elements and their impact on the needs and expectations of the community supported these example scenarios.

The need for models of service delivery to be determined by factors in the individual community is consistent with views expressed in the literature

(Burley and Greene 2007). Community consultation is therefore the foundation on which health service provision must be configured, or in some cases reconfigured, to move from the current interventionist model. This consultative and multidisciplinary approach to health care services and delivery at the population level can assist in preventing illness and improving the overall health of the community

(Queensland Health 2004). To facilitate this new approach the primary health care workforce of the future must be educationally prepared to lead the shift from traditional models of health care service and delivery towards a more comprehensive and integrated population health approach (Dade Smith et al 2006).

**Figure 1: New Model of Health Service Delivery and Care.**



## CONCLUSION

In remote or isolated areas of Queensland, achieving a functional model of health service delivery will require the integration of the philosophy and principles of primary health care, an appropriate skill mix of staff, consistency in working conditions, a minimum inventory of equipment, sophisticated levels of information technology, and a clear and consistent communication strategy. It is important that staff members have access to appropriate education and training activities, to support the implementation of changes in models of health service delivery that will best serve the needs of each individual community.

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# Registered nurses' opinions about patient focused care

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## KEY WORDS

Patient focused care, nurse opinions, nursing care delivery model, management

## ABSTRACT

### Objective

The aim of the present study was to investigate registered nurses' (RN) opinions about the organisational change to patient focused care (PFC).

### Design

A qualitative explorative design and an interview guide with open-ended questions were used.

### Setting

One ward at a university hospital

### Subjects

Six female registered nurses

### Main outcome measure(s)

The interview questions included items about 'experiences of PFC', 'experiences of one's own professional role' and 'opinions about the quality of care in the model'.

### Result

All of the interviewed nurses at the ward had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. The interviewees emphasised, however, that if one is to make a fair evaluation, more experience of working with PFC as well as total implementation of the model is needed. The interviewees did report positive effects of PFC, which they believed gave all employees at the ward greater motivation to work towards continuous development.

### Conclusions

The RNs in the present study had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. The present study illustrates nurses' experiences of working at a ward that uses PFC as its organisational form, and this knowledge is valuable to nursing managers who are considering organisational changes. The interviewed nurses found that PFC had many advantages and that the organisational form could therefore be suitable in several clinical settings.



## INTRODUCTION

An organisational model at the ward level called PFC has become quite popular in Sweden during the past decade and has been introduced on many wards (Landstinget i Värmland 2010). However, few evaluations have been made of how the model works. The purpose of the present paper was to report on a study investigating RNs' opinions about working according to a model of PFC in a university hospital ward in Sweden. The paper begins with a description of the concept of PFC. Thereafter follows a short review of previous studies.

### Patient focused Care (PFC)

PFC originated in the United States of America (USA), where it was developed at Henry Ford Hospital in Detroit at the end of the 1980s. The goal of PFC is to improve care by increasing the time spent on direct nursing care and decreasing the costs of care. Professionals are encouraged to provide more individualised service that responds to each patient's unique concerns and needs (Seago 1999). The development of PFC has thereafter increasingly focused on the patient and is today regarded as a holistic care philosophy, in which the patient is seen in a comprehensive perspective (Jenner 1998). PFC is practised in several hospitals in the USA, the United Kingdom (UK) and Australia. However, there is no specified PFC model; rather each hospital frames its own. According to one common holistic care philosophy, three concepts are central: communication, continuity and congruence (Irwin and Richardson 2006). The foundation of PFC can be traced back to Florence Nightingale, who emphasised nursing care and focused on the patient instead of the illness (Lauver et al 2002).

PFC implies a shift from a task- and routine-based organisation with hierarchical structures, to an organisational model that facilitates more and closer contact with each patient. Having responsibility for fewer patients means the care provider can have closer contact with his/her patients. In PFC, care professionals are encouraged to provide more individualised care that responds to the unique concerns, needs, and wishes of the patient and

families (Mitchell et al 2000). The purpose of PFC is also to promote a more equitable patient-care provider encounter and to encourage the patient to participate more in his/her own care (Irwin and Richardson 2006). Lathrop (1991) suggested that PFC improves continuity in care and empowers staff to plan and execute their work in ways that are most responsive to patients' needs.

### PFC in Sweden

The PFC organisational model was described in an article in a Swedish journal (Landstingsförbundet 1998). A Swedish head nurse became interested in the model and introduced a modified version of it on a surgical ward. She introduced the model because she had experienced shortcomings in care, too little time for patients, and too many routines (Carlsson and Inde 2006; Inde 2007, Landstinget i Värmland 2010).

In Sweden, PFC is characterised by its aim: to increase staff members' time for patients and their possibility to come closer to patients. To enable this, RNs are relieved of a great deal of administrative work, which instead is transferred to a receptionist or coordinator. This person is responsible for the ward's communication function, all the paper work concerning patients and the distribution of incoming phone calls to the appropriate nurse. The RNs and assistant nurses work in care pairs; they plan, prioritise and allocate the work together, prior to and during their work shift, and they work as teams. They are jointly responsible for the patient's nursing care. In order to provide individualised care, it is important to have a comprehensive view of the patient. This means the team can only be responsible for a limited number of patients.

The model is based on the idea that care should take place in close connection with patients, and the prerequisite for this is that RNs be relieved of as much administrative work as possible. This should result in RNs being more available for patients and in their working time being more concentrated on direct care in encounters with patients. This, in turn, is expected to lead to more personal care and care in which the patient participates. PFC allows RNs

to do what is unique to their competence; they no longer have to prioritise administrative duties at the expense of nursing care. At the end of the shift, they jointly evaluate their day's work. Administrative duties that require the competence of a RN are carried out at small working stations, or modules, near the patients, instead of at larger nursing stations (Inde 2007, Landstinget i Värmland 2010).

### Literature review

A number of studies on PFC have been published, but the meaning of the concept is defined differently in different countries. The literature related to PFC that comes from the USA and Canada is mostly focused on emergency hospital care. The literature on PFC coming from the UK also deals with community-based medicine (Aitken et al 2001). The present review concerns only studies conducted in the hospital environment.

Studies on PFC have revealed both positive and negative opinions. Patient surveys have shown that patients prefer PFC (Irwin and Richardson 2006). Mitchell et al (2000) showed that patients felt they were seen as individuals and could participate in care. Carter et al's (2008) findings reveal that both RNs and patients on a ward with PFC organisation perceived a high level of caring. Brider (1992) described how time is saved when nurses are cross-trained and can perform as much as 90% of the services. Tonuma and Winbolt (2000) and Mitchell et al (2000) emphasised that staff members' work satisfaction increases in PFC, because they have more opportunities to become involved in each patient. Bickler (1994) and Tidikis and Strasen (1994) found that PFC reduces costs, and Seago (1999) and Redman and Jones (1998) found just the opposite. Seago (1999) showed that PFC did not entail any advantages for patients. Seago (1999) also showed that RNs' work satisfaction decreased when PFC was introduced. Ingersoll et al (1999) revealed that introducing PFC entails considerable work for nursing managers as regards trying to get the model to function in practice.

However, few studies have looked specifically at RNs' opinions about PFC. No study was found that investigated RNs' opinions about PFC in Sweden,

only a few small-scale evaluations showing positive results, such as fewer calls from patients' rooms and higher work satisfaction among staff (Landstinget i Värmland 2010).

### Aim

The aim of the present study was to investigate RNs' opinions about the organisational change to PFC.

The specific study questions were:

What has the transition to PFC meant for RNs on the ward?

What are RNs' views on their own professional role in PFC?

What are RNs' experiences of quality of care after implementation of PFC?

### METHOD

#### Design

A qualitative explorative design was chosen using an interview guide with open-ended questions.

Settings – description of the hospital and ward

The study was performed in central Sweden at a university hospital with 1,100 patient beds and 8000 employees, 2,800 of them RNs. It was conducted on a ward for infectious diseases, with 28 patients beds and 57 employees, 31 of them RNs. The development project initiated to introduce PFC had started one year before the study began. The aim of introducing PFC in the ward was to improve the quality of care as well as to increase the care staff's work satisfaction. The organisation of nursing care was to change from a task- and routine-based working system to a much more patient-focused way of working. The care staff would then have more time to spend with the patients. Before implementation of PFC on the ward, the care staff worked in larger groups and the work was fragmented when so many people shared to entire administrative responsibility. Much of the nurses' time was stolen when they were disturbed by constantly ringing telephones and had to answer phone calls that did not concern their own patients. In PFC, administrative duties and incoming phone calls are instead handled by a receptionist, and this

gives RNs more time for their patients and enables them to work in a more patient-focused manner. The smaller number of care staff around each patient leads to higher continuity of care, and working closer to the patient leads to more individualised care with opportunities for increased participation. The work in care pairs is dependent on close communication and cooperation between the RN and the assistant nurse, and this is meant to increase collaterality between the professional groups.

In planning the implementation, most of the staff participated in different working groups that discussed and planned how the development project should be carried out. This preparatory work also included some measurements, such as the number of telephone calls and calls from patients' rooms. The present study began after PFC had been in operation on the ward for half a year. Note, however, that at this point the ward had not been appropriately reconstructed to fit the care model. Part of the development project was to make continuous evaluations of how PFC was working, and the present study was part of these efforts.

### **Selection of participants and procedure**

Permission to carry out the study was obtained from the head nurse at the ward. Informants were chosen so as to include RNs with experience of working both in PFC and in wards with a 'traditional' organisation. All six informants were women in the age range 28-33 years, and they had worked on the ward between one and a half years and four years. The mean age of the RNs on the ward at the time of the study was 32.5 years.

### **Data collection**

The qualitative interviews were performed using an informal interview technique, in the form of a conversation focusing on the informant (Kvale 1996). The interviews were jointly conducted by two persons (AK and LK). One was responsible for the interview and the other followed up with complementary questions and operated the tape-recorder. The interview technique was open-ended, and an interview guide with target themes was used. The themes were 'experiences of PFC', 'experiences of one's own

professional role' and 'opinions about the quality of care in the model'. The interview started by asking RNs to describe their experience of working at a ward with the PFC organisational model. All questions were supplemented with follow-up questions that encouraged informants to provide rich descriptions and allowed them to describe their opinions and feelings. The interviewer's role was to encourage the informants to reflect on the question and to make additional comments such as 'please tell me more about that'. Interviews took place at the informant's workplace in a quiet room. Each interview lasted between 30-60 minutes. Interviews were tape-recorded with the informant's permission and then transcribed verbatim by the interviewers.

### **Data analysis**

The interviews were analysed using a qualitative method, i.e. latent content analysis, inspired by Graneheim and Lundman (2004). The analysis began by reading the text several times in order to become familiar with it and to understand its overall essence (Sandelowski 1995). The next step was to make detailed marginal notes, including open coding: 'working headings' based on all of the information in the text related to the aim of the study, i.e. RNs' opinions about PFC. Meaning units that dealt with the open coding were then identified. All meaning units were critically analysed and contemplated until suitable categories emerged. These categories were then sorted under target themes, which are the same as the specific study questions (Graneheim and Lundman 2004, Sandelowski 1995). Data analysis was carried out in 2008.

Describing both data collection and the steps in the analysis constitutes a way of establishing credibility, which is in line with Lincoln and Guba's (1985) description of establishing the quality and trustworthiness of qualitative data and analysis. Dependability is a criterion used to measure trustworthiness. This is met in the present study by demonstrating the credibility of the findings. Procedure descriptions and the discussion linking the present study to other studies with similar findings are the most important ways of establishing dependability

here. Furthermore, quotations are provided that are illustrative of each theme. Confirmability has been established through description of the analyses.

### **Ethical considerations**

All participants received information about the aim of the study and were told that participation was voluntary. The two people who conducted the interviews had no connection to the interviewees. The data have been treated confidentially. Thus, the recommendations made by the Swedish Council for Research (Codex) have been followed.

## **FINDINGS**

The themes and categories are summarised in table 1 and presented in detail in the text.

**Table 1: Themes and categories.**

<b>RNs' experiences of the transition to PFC</b>
The process of change
Decreased administration
Cooperation in care pairs
Workload
Patient contact
Reconstruction
<b>RNs' views on the nursing profession in PFC</b>
Changed focus
<b>RNs' views on the quality of care in PFC</b>
Change in quality of care
Factors affecting quality of care

### **RNs' experiences of the transition to PFC**

#### ***The process of change***

All of the interviewed nurses at the ward had overall positive attitudes towards PFC and felt the care model could facilitate nursing practice. They thought PFC is a model that focuses on the right thing: the patients. The interviewees emphasised, however, that more experience of working with PFC is needed if one is to make a fair evaluation of the model. Total implementation of PFC is also needed. For instance, the ward needs a proper reception and several stationary modules for the nurses to work at. The interviewees also emphasised that the transition to PFC is a process of change that takes time. It must be a gradual change, given that the care model has

to be modified according to the specific needs of the ward. The process of change is also individual, and the nurses must all be patient with each other and let it take time. The interviewees did report positive effects of PFC, which they believed gave all employees at the ward greater motivation to work towards continuous development.

'It's good that we're introducing it gradually, because it's a process of change that has to happen and we're a big group of staff, but the changes we've made so far have encouraged us to continue with this concept... you can see that in the end the care is better and you have more control over what is happening with the patient.'

#### ***Decreased administration***

Among the interviewees, the most appreciated change associated with PFC was that a ward secretary now takes all incoming phone calls. The nurses only have to answer calls directed at them and that concern their patients. This frees the nurses from unnecessary phone calls and stress, and more time is available to spend with patients. The working environment is now less stressful and quieter without the disturbing telephone signals. The ward secretary also has administrative responsibilities, and because the nurses no longer have to handle patient logistics, more time is left for patient care.

#### ***Cooperation in care pairs***

Most of the interviewed nurses experienced better cooperation with the assistant nurse in the care pairs when working with PFC. Nurses are now more accessible when they are stationed closer to the patients, and this makes their work more efficient. There is a feeling of really working in a team with the joint aim of focusing on the patient.

'What we've carried out so far has done a lot for... well, for the ward but also for me, my way of thinking about working with the assistant nurse who is part of my team, so I think it's and I think generally on the wards it's made a lot of people think, we've learned to prioritise our duties not only based on what I have to do, but on what we have to do with the patient.'

Making a plan for the day at the beginning of the work shift and having continuous communication in the care pairs in order to reprioritise are two aspects that are important to the cooperation. The interviewees stressed the importance of two-way communication.

### **Workload**

In the implemented PFC model, the nurses, working with the assistant nurse in their care pair, are supposed to provide basic nursing care for five to seven patients. Some of the interviewees experienced this as a heavier workload than before and felt it was sometimes impossible to accomplish the actual nursing care because they still had their medicine assignments. This of course depends on the type of patients being cared for. Some of the interviewees felt guilty when they did not have enough time to help the assistant nurse. The RNs also perceived frustration among the assistant nurses when they sometimes had to do the nursing work alone. On the other hand, some of the interviewed nurses experienced an easier workload, because they now had fewer patients and less information to keep in mind. Some of the interviewees, however, reported not experiencing any difference in workload with PFC.

### **Patient contact**

When working with the PFC model, the nurses are physically closer to the patients, and this was a very positive experience for the interviewees. The nurses are supposed to work at small modules situated close to the patient rooms, and this makes it much easier for them to answer calls from the patients. Half of the interviewees experienced that their time for patients had increased with implementation of PFC and they were now more involved in direct care. The fact they now spend more time with patients allows nurses to get to know their patients better, which results in a better and more comprehensive understanding. One nurse felt increased patient contact improved work satisfaction. Some of the interviewees still thought they had too little time for the patients and that the assistant nurse was the one actually seeing the patients most of the time.

### **Reconstruction**

There was consensus among the interviewees concerning the need for reconstruction of the ward. The fact that, at the time of the present study, the workplace was not yet appropriately constructed to fit the new care model made it difficult to fully work according to the model. The nurses need real working modules with a stationary computer at a desk and a chair to sit on. In the studied situation, the nurses had to stand in the corridor and work at temporary modules consisting of medicine carts equipped with a laptop. This made it difficult to write in patient journals owing to disturbances in the corridor and the lack of privacy. It was also difficult to make phone calls to relatives. Some of the interviewees, however, thought that, thanks to the more accessible working modules, it was now easier to carry out continuous documentation during the work shift than it had been before.

Most of the interviewed nurses emphasised the need for a proper reception in conjunction with admittance onto the ward. The receptionist should take care of visitors and relatives, showing them to the right room.

### **RNs' views on the nursing profession in PFC**

#### **Changed focus**

Most of the interviewed nurses did not experience any difference in their professional roles when PFC was introduced. However, it has brought about changes in the nurses' attitude towards their work and has put more focus on patients. Some nurses felt the focus had shifted from their own manifestation of the work to the patients. They now always worked in a patient-focused manner. Before PFC, the nurses' work had been more focused on specific tasks and routines and the patients themselves were sometimes in the periphery. Some of the interviewees pointed out that they are all in the midst of a major process of change and the focus is therefore sometimes more on the collaboration in the care pairs than on the patients.



Many of the interviewed RNs experienced more distinctive roles as team leaders when working with PFC. They felt responsible for planning and structuring the work in the care pairs and this ability had developed.

'...I've become better at making a plan for me and my assistant nurse, for our team, and that's a large part of our ... professional role, I mean ... planning my own and the assistant nurse's actions. So I think in that way I've developed a bit. I sort of boss more, not really, but almost!'

However, some of the interviewees wished the assistant nurses were more independent and better able to take the initiative. Nevertheless, the work in care pairs did give increased understanding of the different professional roles in the care pair, which is important to making a good team.

#### **RNs' views on the quality of care in PFC**

##### ***Change in quality of care***

Most of the interviewees agreed PFC had given them an improved comprehensive view of the patients, and this was seen as a quality indicator. When nurses participate more in direct nursing care, they get to know the patients better and can provide more patient-focused and individualised care. The nurses who experienced having more time for each patient when working with PFC felt this facilitated higher quality of care. They now had more time to do additional things for their patients, things that are often of great importance to patients. Some of the interviewees, however, had not observed improvements in the quality of care with the PFC model, but they were now less stressed at work, which made it easier to maintain the quality of care. These nurses felt they still did not have enough time and more personnel were required. They did not believe that PFC alone could solve the problem of the sometimes very heavy patient load experienced on the ward.

##### ***Factors affecting quality of care***

There was consensus among the interviewees about the improved cooperation in the care pairs and this has had a positive effect on the quality of

care. Another positive effect is that the nurses work physically closer to the patients and are therefore more accessible. The fact that the assistant nurses now participate during rounds was also seen as a quality indicator. This gave assistant nurses a better understanding of the patient, making them more highly motivated to do the work. The assistant nurses also provided a great deal of valuable information about the patients.

'They're more motivated to take blood pressure measurements, temperature, weight and everything... when you understand why they should be taken it's easier to take them... and that improves the quality.'

There was consensus among most of the interviewed nurses the patients seemed to be more satisfied and secure with PFC, due to the decreased number of staff around the patients. Some of the nurses emphasised the importance of making decisions together with patients to increase their participation in the care.

## **DISCUSSION**

The result of the present study reveals overall positive attitudes towards the PFC care model amongst the nurses at the ward, but also that more experience of working with PFC is needed.

PFC, as performed in Sweden, is supposed to increase the RN's time for direct nursing care (Inde 2007). This was only experienced by half of the interviewees in the present study. These nurses felt they had more time for patients because they no longer had to perform administrative duties and take incoming phone calls. They were now instead more involved in direct nursing care. The other interviewed nurses still thought they had too little time for their patients and nursing care. They also felt a heavier workload than before PFC owing to the nursing care. These nurses felt the change from administrative duties and phone calls towards expanded nursing care had given them even more things to do, and this could be stressful. One reason why only half of the interviewed nurses experienced more time for patients could be that the nurses still had their medicine assignments, which

take time. When there are many patients requiring extensive care, this often implies that the nurses have to prioritise the medical part of their role at the expense of nursing care. In these situations, the nurses' focus was drawn away from the patients and back to the tasks and routines again. Jenner (1998) showed that during introduction of PFC, the focus was on cross-training and the specific task skills. Hopefully, as the care staff develops along with PFC, the focus will gradually be shifted to the patients.

Another reason could be the PFC model had not yet been completely implemented on the ward at the time of the study, and the nursing staff were in the midst of a major process of change. It takes time to change work routines and to change people's approaches to their work. Mitchell et al (2000) emphasised that it takes time to implement a new care model in hierarchical structures and that PFC constitutes a change in the entire healthcare paradigm. PFC means shifting from a mechanistic paradigm, in which patients are seen as parts and problems, to a holistic healthcare paradigm that sees human beings and their health experiences (Mitchell et al 2000). PFC also implies a shift from a task- and routine-based organisation, to an organisational model that can facilitate more and closer contact with each patient: having responsibility for fewer patients means the care provider can have closer contact with his/her patients. This could help nurses provide more individualised care that responds to the unique concerns, needs, and wishes of the patient and families, as described by Mitchell et al (2000). Furthermore, nurses could promote a more equitable patient-care provider encounter and encourage the patient to participate more in his/her own care, as emphasised by Irwin and Richardson (2006). Utilising PFC could be one way of trying to apply the ideas of Florence Nightingale, who emphasised nursing care and focused on the patient instead of the illness (Lauver et al 2002).

Ingersoll et al (1999) showed that nursing managers found their leadership role difficult after the introduction of PFC, largely owing to the tension between the old and the new paradigm. However,

the nurses experienced that PFC brings with it a comprehensive view of patients that facilitates the work and also gives increased work satisfaction. Tonuma and Winbolt (2000) and Mitchell et al (2000) emphasised that work satisfaction increases because staff have more opportunities to get involved in each patient when working with PFC. Reisdorfer (1996) also showed an increase in staff work satisfaction as a benefit of PFC, and the highest scores were found with respect to collaboration among team members

Irwin and Richardson (2006) showed that patients prefer PFC, and Mitchell et al (2000) showed that, with PFC, patients feel they are seen as unique individuals who can participate in their own care. Seago (1999) found no change in patient satisfaction after implementation of PFC. In the present study, there were divided opinions as to whether PFC leads to higher quality of care. Some of the interviewees did not experience any difference in the quality of care and did not think PFC could solve the problem of the heavy patient load. These nurses wished for more care staff. Some other of the interviewees experienced that, with PFC, the patients seemed to be more secure and have more faith in the nursing staff owing to the limited number of nurses involved in caring for them. Patients also emphasised the nurses at the ward were more accessible when working at the modules, and that this and the improved cooperation in the care pairs were positive factors that improved the quality of care. Most of the interviewees agreed, however, that the improved comprehensive outlook on patients brought about by PFC is an indicator of higher quality of care. However, there is a need to investigate patient satisfaction with PFC in Sweden. The present study discusses only the nurses' experiences of and thoughts about the quality of care, but it says nothing about patients' opinions of PFC.

In the present study, the majority of nurses interviewed experienced better cooperation and team work in the care pairs when working with PFC. They plan and structure their work together, and this gives an improved understanding of the different

professional roles. This also involves the doctors in the ward, because they meet the care pair during rounds and can communicate directly with both the nurse and the assistant nurse. Redman and Jones (1998) identified the unifying effect the implementation of PFC had on the overall organisation. Achieving a stable organisational change depends on having good leadership (Inde 2007). Ingersoll et al (1999) investigated the effect implementation of PFC had on midlevel nurse managers and found they had difficulties keeping up with the demands of the change. Redman and Jones (1998) also found that managers faced considerable challenges and changes in their responsibilities when the new model of care was implemented. Because redesigning a care-model also affects nurse managers to a great degree, studies of how nurse managers experience the move to PFC on Swedish wards would be valuable.

Bridger (1992) discussed the issue of whether nurses' professional role could be diminished by PFC and specifically the cross-training required. There is no such training in the Swedish model of PFC, but it raises the question of whether the nursing profession should be mixed with the profession of the assistant nurse. In the present study, most of the nurses did not experience any difference in their professional roles with PFC, even though they now do more nursing care, which in traditional care models is performed mostly by the assistant nurses. The interviewed nurses felt that nursing care is a self-evident part of a nurse's job and the expanded nursing care resulting from PFC does not cause the nursing role and the nursing assistant role to be mixed. PFC implies flattened management structures (Aitken 2001) and focuses on teamwork across professional boundaries, the aim being to benefit from the total competency (Inde 2007). This should not blur the professional roles, but rather increase nurses' and nursing assistants' understanding of each other's work, thus helping to reduce the hierarchical structures found in the healthcare system.

Because the model of PFC used on the present ward was modified by a Swedish nurse, it has been difficult to compare the work on the ward with the

literature on PFC as it is performed in the USA and Canada. A comparison of the implementation of PFC in different countries also means comparing the nursing profession and nursing education, which differ considerably across countries. Although there are different variations of PFC, they all originate from the same holistic care philosophy and they all aim at improving the care provided and at focusing on the patient.

At the time of the study, working with PFC was still new to the staff at the present ward, and the care model had not yet been completely implemented. The transition to PFC may take many years, as it involves a fundamental shift in the worldview or paradigm underlying how nursing staff think about their work. It is not enough to tell staff they must think differently. Changing beliefs, values, and practices is no small matter.

### **Methodological considerations**

Having two interviewers working together was an advantage, as it made covering all themes in the interview guide easier. On the other hand, it may have been stressful for the interviewees. The conformability of the data was strengthened by presenting several quotations in the results; this helps the reader understand the interpretation (Sandelowski 1994). To strengthen dependability, analysis of the text was carried out by two authors and validated by the other authors (Polit and Beck 2007). The relatively small convenience sample could be a limitation and may affect the study's transferability. It would also have been interesting to investigate the assistant nurses' opinions about working with PFC, but there was not enough time for this during the study period.

### **CONCLUSIONS**

The aim of the study was to investigate RNs' opinions about the organisational change to PFC. The results show that the interviewed nurses had overall positive attitudes towards the new care model and that PFC could be a way of facilitating nursing practice. More experience of working with PFC is needed as well as total implementation of the care model, including

reconstructions. Further research will focus on patient satisfaction, the opinions of the assistant nurses as well as the impact the shift to PFC has had on nurse managers.

During the literature review, no studies on RNs' opinions about PFC in Sweden were found. This study is therefore important in that it highlights the Swedish model. It is also valuable for further research and for other hospital wards that wish to introduce PFC.

### Implications for Nursing Management

The present findings show that the interviewed RNs had overall positive attitudes towards PFC. They found that PFC had many advantages, and the organisational form could therefore be suitable in several clinical settings. The study illustrates nurses' opinions about working on a ward with PFC as an organisational form, and this knowledge is important to nursing managers who are considering organisational changes.

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# Casualisation in the nursing workforce – the need to make it work

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## KEY WORDS

nursing workforce; non-standard work; casualisation; flexibility

## ABSTRACT

### **Objective**

The aim of this paper is to highlight some of the challenges faced by the nursing profession in response to increased casualisation of its workforce and why the presence of casualisation needs to be viewed in a positive light.

### **Setting**

The nursing workforce worldwide.

### **Subjects**

Nurses who need or want to work as casuals.

### **Primary argument**

The care-giving responsibilities of a predominantly female workforce and the ageing of the nursing workforce worldwide means some nurses are choosing or need to work as casual employees in order to remain in the workforce. Historically, casuals have been viewed in a negative light particularly in discussions around commitment and continuity-of-care. Without a change in attitude towards nurses who work as casuals, a significant portion of the nursing workforce may be lost.

### **Conclusions**

An ageing nursing workforce coupled with a worldwide shortage of nurses means that employers need to ensure options are available to accommodate nurses requiring flexible rosters in order to encourage recruitment and retention. Policies are needed to ensure that all staff, regardless of their contribution in hours, feel valued and supported and are able to contribute to their profession. Maintaining a portion of the workforce in a flexible form will allow increased staffing options and ensure that sufficient experienced staff are available in order to maintain quality patient care and outcomes.



## INTRODUCTION

Increased casualisation of the nursing workforce in recent years has culminated in a greater percentage of nurses working in non-standard forms of employment such as part-time and casual. One of the main drivers for casualisation during the restructuring of the health workforce was to increase its productivity and competitiveness. Exchanging full-time employees with largely benefit-free casual staff was viewed by employers as sound economics as casual staff were able to be utilised according to patient and workforce requirements. Non-standard forms of employment often suit workers with family or care giving responsibilities, those wishing to gain extra income or pursue education or training, or those wanting to have flexible or decreased work hours. Whether casualisation is driven by employers of nurses or the nurses themselves, non-standard work arrangements are likely to be an ongoing feature of the contemporary nursing workforce and demands strategies to ensure it contributes positively to staff and patients experiences.

## DISCUSSION

### Casualisation and the nursing workforce

The move away from standard full-time work to more flexible forms of non-standard work has largely been driven by competitive and economic pressures, deregulation of the labour market and the need for greater flexibility in organisational structures (Allan 2000). Non-standard work is associated with any other form of work that is not 'standard', for example casual, agency and part-time work. 'Casualisation' occurs when there is a shift from predominantly full-time and permanent positions to an increased number of casual positions. The shift towards casual work in Australia has continued to rise to a level where approximately one in four Australian employees are classified as being engaged in a form of casual work (Voltz 2007; May et al 2005; Creegan et al 2003) which is one of the highest rates in the industrialised world (Voltz 2007). In the United States of America (USA) approximately 20-27% of workers in the education and health sector are classified

as working in a non-standard form of work (Bureau of Labor Statistics 2005) and in Canada 32.5% of registered nurses (RNs) work part-time with 10.1% as casuals (ICN 2008). It is suggested that people who undertake casual work are employed on a short term or irregular basis with no set hours (Nesbit 2006). These 'casuals' receive an increased hourly rate of pay to compensate for the loss of access to benefits such as paid holiday and sick leave, which are normally associated with full-time and permanent part-time positions (Murtough and Waite 2000).

From an employer's perspective, the growth of non-standard work practices in nursing is a response to management restructuring to provide a more efficient workforce able to respond to economic changes on a national and international front (Lumley et al 2004). From the employee's perspective, this has provided an opportunity to combine work commitments with responsibilities such as family and other interests (Department of Employment and Workplace Relations 2005; Creegan et al 2003) particularly for the predominantly female nursing workforce (Whitlock et al 2002) seeking family-friendly employment opportunities.

Maintenance of a core full-time workforce coupled with the ability to 'top up' as demand dictates, is an effective human resource strategy. Although casualisation was originally a means to increase the flexibility of the workplace, changing demographics have seen casual staff being used to assist with the nursing shortage (Edwards and Robinson 2004). Several studies (Lumley et al 2004; Aitken et al 2001; Godfrey 2000) have found that lack of permanent and/or full-time staff has resulted in organisations using casuals to fill shifts on an almost permanent basis rather than for sick leave or seasonal demands as was the trend previously.

### Casualisation and the ageing nursing workforce

Data from Canada reports that for every RN under 35 years of age there are two RNs over the age of 50 (ICN 2008) and this is similar to Australian data where there are approximately 54,000 RNs under 35 years of age and approximately 110,000 RNs over 45

years of age (AIHW 2009). Retirement plans are on the agenda for the 'baby boomers' (those born between 1946 and 1964) (Cowin and Jacobsson 2003) and from 2011 they will start to leave the workforce in large numbers. However, because of longer life expectancy (Kraill 2005) or for financial reasons (Palumbo et al 2009) such as the recent global financial crisis which impacted on savings and/or benefits (Halsey 2009; Lavizzo-Mourey 2009; Rampell and Saltmarsh 2009), some may choose to retire later or transition into retirement more gradually. Schofield et al (Schofield et al 2006) predict that half of the current nursing workforce will retire in the next 15 years. In Australia, The Senate Community Affairs Committee report 'Inquiry into Nursing' (2002) predicts that 30% of its current nursing workforce may be lost during this same period. In the USA, it has been projected there will be a need for between 400,000-800,000 RNs by 2020 to satisfy the gap between supply and demand (Buerhaus 2005).

Although nursing has experienced shortages before (Purnell et al 2001), this period of decreased supply is occurring as the pool of current workers is ageing in parallel with a population that is ageing, thus increasing the demand for health care (O'Neil 2003) and health care professionals (Buerhaus 2005). Projections for the nursing workforce through to 2025 indicate the need to continue strengthening numbers to meet these needs (Buerhaus et al 2009). Strategies to meet these expectations are needed to ensure the health care system remains able to provide affordable, accessible, high quality health care. Although casualisation is by no means a panacea to address these issues, it provides a workforce that can be used flexibly to address the shortage of staff.

As the workforce ages, the loss of older workers and their corporate and discipline specific knowledge, expertise and skills means the loss of valuable corporate intelligence (Ward-Smith et al 2007). Andrews et al (2005) found that in the United Kingdom (UK) nurses over 50 years of age indicated a lack of flexibility in work hours was a major factor influencing their decision about whether to continue

participating in the nursing profession. Another factor influencing this decision is the dissatisfaction felt by any individual who works below their capacity, training or education which also affects their attitude towards their work and employment (Holtom et al 2002). Dissatisfaction in the workplace due to hours worked and underutilisation of knowledge and skills is an important retention and recruitment issue (Knox et al 2001). Baumann et al (2001) highlight that nurses 'work best' when they have some control over their work hours and are able to perform within their full scope of practice. Allowing knowledgeable and skilled employees to be dissatisfied or underutilised is potentially detrimental to quality patient care and to the nursing profession (Edwards and Robinson 2004). Organisations and governments need to consider strategies to keep these employees in meaningful work (Blakeley et al 2008; Ward-Smith et al 2007; Robert Wood Johnson Foundation 2006).

### **Casualisation and flexibility**

Casualisation of the workforce has also occurred in an endeavour to satisfy the need for flexibility (ICN 2002). Evidence from the nursing workforce in the UK, the USA and Australia has shown that many nurses choose casualisation over permanent positions because of higher hourly pay, more incentives and flexibility over when and where they work (Gordon 2004; Lumley et al 2004; Creegan et al 2003).

An Australian Government report (Standing Committee on Employment Workplace Relations and Workplace Participation 2005) proposes that more casual positions are needed to encourage more workforce participation, especially amongst women and mature-aged workers. The Australian Nursing Federation's (2008) submission to the Standing Committee on Employment and Workplace Relations stresses that a key factor to increasing workforce participation by nurses is flexibility around work schedules and hours worked.

Some authors report that casualisation has been used to address retention and recruitment challenges in Australia (Aitken et al 2001) Scotland (Buchan 2002) and the UK (Edwards and Robinson 2004)

however in order to retain and recruit staff work preferences must be taken into account (Blythe et al 2005). Nurses who can work their preferred hours and schedules have been found to demonstrate greater satisfaction in their work and a lower intent to leave the workplace (Holtom et al 2002).

To remain efficient in the current climate and be able to compete for the smaller pool of workers available, employers of nurses need to implement strategies that include non-standard forms of work. While casualisation presents many opportunities for employees to stay or move into the nursing profession, discussion around casualisation has often had a negative focus, with concerns for commitment to the profession and patient care and outcomes regularly raised as issues.

### **Casualisation and commitment**

Historically, non-standard forms of work have been undertaken by less skilled and less committed workers (Galais and Moser 2009; Edwards and Robinson 2004). Richardson and Allen (2001) support the view that the term 'casual' carries with it many assumptions, but argue that nurses in casual employment have the same education and experiences as their full-time colleagues. Several authors argue that commitment to an employer is influenced by the type of employment chosen and that many part-time workers are female who have chosen family commitments over commitments to a career and hence employer (Whittock et al 2002). In study findings involving nurses, positive correlations between job satisfaction and organisational commitment highlight the need to support employment choice where possible (Ingersoll et al 2002). For many nurses who choose to work flexible schedules and/or hours, job satisfaction and organisational commitment may be influenced by how well they are able to integrate both work and family commitments.

Keeping up to date with contemporary practice can be problematic for nurses who work as casuals as they may not be integrated into an organisation's staff development opportunities (Allan 2000) due to their high numbers and turnover. The potential to

lose track of the yearly mandatory competencies and other more specific workplace education and training is a genuine concern. Nurses who work as casuals are often asked to cover for permanent staff while they attend professional development activities and FitzGerald et al (2007) report that one nurse in their study had not attended an in-service during the ten years she had been in the casual pool. Even in light of the self-regulation required for registration with many nursing boards, FitzGerald et al (2007) found that none of the nurses working as casuals in their study discussed accessing information resources for themselves.

Type of employment (full-time, part-time, casual) must be taken into consideration by employers wherever possible because voluntarily undertaking non-standard work (including casual and temporary) has a positive impact on work related attitudes and behaviours (Connelly and Gallagher 2004). If commitment is in part related to ability to choose employment status, strategies and policies need to be implemented to ensure casual employees are offered the same education and training as their permanent/full-time counterparts, or supported to do this themselves, in order to ensure that even in the constantly changing nursing environment, quality patient care and outcomes are maintained.

### **Casualisation and continuity of care**

Strategies used by some organisations to address continuity of care include the operation of a nursing pool or having nurses who 'float' between areas, which also provides multi skilling and improved utilisation of staff (Rudy and Sions 2003). These 'float' nurses work within one organisation and are assigned to different areas as needed each shift (Rudy and Sions 2003; Richardson and Allen 2001). This flexibility has provided the employer with valuable options in how they utilise their staff as well as opportunities for staff to extend their knowledge and skills across the workplace which may help maintain a high standard in patient care and safety (Richardson and Allen 2001). 'Floating' nurses may provide employers with an alternative staffing strategy but it has not always been found

to be a significant factor in staff satisfaction and may lead to retention concerns, as reported in one study in which 'floating' was a driver for nurses to leave an organisation (Ferlise and Baggot 2009). Another initiative used to accommodate flexibility needs of staff was the implementation of four, six, eight and twelve hour shifts in some workplaces (Kalisch et al 2008). Although improved flexibility was an outcome, this model often led to chaos in the workplace with constant changes of staff leading to ineffective teamwork and the constant reassigning of staff throughout the day threatening patient care and safety (Kalisch et al 2008). Continuity of care may be difficult to ensure through these strategies as it could be argued that the nurse who 'floats' around their organisation or who works varying shift lengths is a form of casual nurse within that organisation.

Although concern over continuity of care has often been raised in relation to the negative impact of casualisation on patient care and potential outcomes (Blythe et al 2005; Burke 2004; Grinspun 2003; Aitken et al 2001; Richardson and Allen 2001) data would suggest some form of casualisation will remain. The issue of continuity of care has been acknowledged by the Australian Council for Safety and Quality in Health Care (ACSQHC), responsible for developing the 'National Patient Safety Education Framework' (ACSQHC 2005). Objective 4.4 'Providing continuity of care' (ACSQHC 2005) (pp. 181-188) states that the impact of having casual or short-term nursing staff must be factored into policies and protocols to ensure issues around continuity of care are addressed by all levels of the health care workforce. These policies and protocols should include training and infrastructure ensuring that the presence of casual staff in the workforce is incorporated into the design of patient services to ensure positive patient outcomes. This framework can provide clear evidence and guidance for workplaces in two ways: (i) by initiating the implementation of strategies to ensure that patient safety and care is not jeopardised because of casualisation and, (ii) that staff, whatever their work status, remain valued and included.

However these ideals are not always achieved and it has been reported that casual staff were considered by nurse managers to be less committed to both the nursing profession and the organisation and 'interrupted the continuity of patient care provided by permanent staff' (Allan 2000) (p. 195). Nurses believe that a heavy reliance on part-time and casual staff contributes to potentially putting patients at risk (Grinspun and Finkle 2003). Indeed, several studies have shown a strong correlation between the number of full-time registered nurses and reduced adverse events involving patients (Royal College of Nursing 2006; Clarke and Aiken 2003; O'Brien-Pallas and Baumann 2000). If casualisation is seen by government and industry leaders to be an ongoing strategy to address workforce challenges, these concerns need to be addressed. Strategies and policies need to be developed that ensure individual nurse's needs are met with the assurance that the delivery of safe, quality care is not compromised.

## CONCLUSION

Casualisation in nursing offers increased opportunities for the predominantly female workforce to remain in the profession. Ensuring wherever possible that staff are able to work according to their own employment preferences while utilising their knowledge and skills, are simple tools that can be used by employers to attract and retain staff. In order to retain older, more experienced nursing staff, implementation of innovative ways to retain them in the workplace need to be developed. Nurses in non-standard forms of work must be valued members of the profession and their contribution to patient care and outcomes must be considered when developing policies and strategies for the future. The profession must find ways to provide opportunities for non-standard work without allowing compromises in patient care and outcomes. Further research and evaluation of strategies and innovations will help guide employers and ensure that casualisation of the nursing workforce provides opportunities for staff and maintains the organisations commitment to the provision of safe, quality patient care.



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# Nursing double degrees: a higher education initiative in times of nursing shortages

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## KEY WORDS

Double degrees, nursing shortages, nursing education.

## ABSTRACT

### Objective

The aim of this paper is to raise awareness of nursing double degrees (DD) and pose questions about their possible impact on nursing shortages.

### Setting

Nursing education in the Australian higher education sector.

### Primary argument

DDs that include nursing are now offered in 13 universities in Australia with over one third of undergraduate nursing students studying by DD mode. The paper argues that the nursing profession should be alert to the growing presence of DD nursing students and graduates and consider the implications of DDs as part of future workforce planning.

### Conclusions

To take account of DD graduates who do not choose to take up a career in nursing, there needs to be an increase in Australian Government funded nursing places and more incentives to remain in nursing. Additionally, where a DD includes a second professional qualification (e.g. teaching, paramedicine) there needs to be some relaxation of cross professional regulations and scopes of practice so that DD graduates can practice in both disciplines.

## INTRODUCTION

The increasing shortages of nurses is well documented globally and locally (Buchan and Aiken 2008; Buchan and Calman 2004; Hegney et al 2002; ICN 2004; WHO 2003). These shortages have a negative impact on the health outcomes of patients. They can also lead to stress and burnout in nurses and then consequently to problems with recruitment and retention (Buchan 2006; Hegney et al 2006b; Morrison et al 2001; van den Tooren and de Jonge 2008). Recruitment and retention issues are not just confined to metropolitan areas but they are also found in rural areas where they can adversely affect the health and sustainability of whole communities (AGPC 2005; ICN 2008; Mahnken 2003; Ryan-Nichols 2004; WHO 2003).

Australia faces a predicted shortfall of between 10,000 to 12,000 registered nurses (RNs) by 2010. To meet this shortfall, at least a doubling of current graduate completions per annum is required (AHWAC 2004). In 2008 the numbers of graduates fell far short with only 7,011 students completing a nursing degree (Preston 2009). Addressing the shortage of graduates presents challenges for the higher education sector, which shares a responsibility with the Federal, state and territory governments, and the nursing profession for ensuring sufficient numbers of qualified nurses to meet present and predicted vacancies (Crowley and West 2002).

### **Undergraduate double degrees with nursing in Australia**

A key initiative from the higher education sector has been the introduction of nursing DDs. DDs involve studying two undergraduate degrees concurrently. DDs can also be termed dual, combined or joint degrees; there is no common terminology used in Australian universities (Batson et al 2002; Russell et al 2008). Over 33% of nursing students study by DD mode (Preston 2009). This proportion is much higher than the 13% of all students who are enrolled in DD programs (GDS 2008). DDs involving nursing are taught conjointly and can be either within a similar discipline area eg Bachelor of Nursing/

Bachelor of Rural Health Practice or across two separate discipline areas eg the Bachelor of Nursing/ Bachelor of Behavioural Science (Psychology). DDs range between four to six years in length depending on the university requirements and the degree of similarity in the combined disciplines. For example, all Bachelor of Nursing/ Bachelor of Midwifery DDs are four years but a Bachelor of Nursing/ Bachelor of Arts in International Studies is five years.

An example of typical DD programs are two offered at Charles Sturt University (CSU) a regional university in New South Wales, Australia. Enrolling nursing students can choose between the three year Bachelor of Nursing or two four-year DD programs: the Bachelor of Nursing/ Bachelor of Clinical Practice (Paramedic) (BN/BCP) and the Bachelor of Early Childhood Teaching (birth to five years)/ Bachelor of Nursing (BECT/BN). As in many other DD programs students choosing these concurrent DDs complete two separate three-year degrees in a four year period and gain knowledge, experience and skills from two disciplines. The BECT/BN gives graduates a very broad understanding of the child, both sick and well, from the hospital to the community setting to child care, while the BN/BCP equips graduates to work in both pre-hospital as well as hospital care areas.

While the growth and popularity of nursing DD programs suggests they may be a positive development, little is known about their impact on the numbers of nursing graduates who choose to work as a nurse. There is a lack of knowledge about why increasing numbers of students are interested in DDs or what their experiences are like while studying two degrees concurrently. Similarly, we know little about their career pathways, whether their career preferences change during their studies, and which career they eventually choose. Indeed they may not intend to do nursing. It is possible therefore that the DD initiative may not provide the panacea that was hoped for.

The purpose of this article is to identify some of the issues and unanswered questions associated with nursing DD programs and to consider their potential

to address the current nursing shortages. The article consists of three sections. The first section provides an overview of the main reasons for the nursing shortages to establish a context for considering the possible impact of DDs. The second section outlines the Australian nursing education context as a key factor influencing the supply of nurses. The third section makes a number of recommendations concerning the necessity to gather baseline data and increase funded places in nursing.

## DISCUSSION

### Reasons for nursing shortages

This section briefly discusses five main reasons for the current workforce shortages. Difficulties include balancing supply and demand through funding mechanisms; recruiting suitable students into nursing courses; and retaining new graduates and experienced nurses. These difficulties are exacerbated by the changing nature of the nursing workforce and expanding career opportunities for nurses outside of nursing.

### Balancing supply and demand

Balancing the supply and demand of nurses through funding mechanisms is an ongoing policy challenge. There was a rapid growth in the number of qualified nurses from the 1960s through to the 1980s as a result of increasing demand arising from the expansion of health services (Preston 2009). The recession in the early 1990s led to sudden cut backs in expenditure by state governments and consequently in the employment of nurses (Preston 2009). Nurses who couldn't find work moved into other areas and, in response to the glut of nurses, governments reduced the numbers of funded places in nursing education (Preston 2009). By the late 1990s when vacancies and replacement requirements began to increase, the supply of nursing graduates was insufficient to meet demand.

A decade later the supply of nursing graduates is still not able to keep up with current demand. The problem is exacerbated by the retirement of large numbers of nurses who entered the profession from the 1960s to the 1980s (ANF 2006; Preston 2009).

Some argue, however, that the problem is not so much a lack of supply of graduates but rather a reluctance of many RNs to take up nursing and to continue to work as nurses in the present conditions (Buchan and Aiken 2008). Whether the growing availability and popularity of DDs will ameliorate or exacerbate the shortage of nurses is unknown.

### Recruitment of suitable students into nursing courses

To address the nursing shortages one strategy of the Australian Government has been to increase funded places in universities for nursing students. Following increases in the number of funded places from 2002 to 2008 (Drury et al 2008), the Royal College of Nursing Australia (2009) reported there were more nursing students being educated in Australian universities than ever before. Many of these places have been taken up by mature age students and increasingly DD students. Mature age students make up over one third of BN student recruits (Drury et al 2008). They are high achievers and have less attrition rates than the younger traditional students (Kevern et al 1999). While mature age students can help to relieve some of the current workforce shortages their likely shorter career spans, and decreased working hours per week (AHWAC 2004) will intensify the shortages predicted in the next decade (Drury et al 2008; Crowley and West 2002).

Nursing shortages are further exacerbated by the reluctance of school leavers to consider nursing as a career, a trend that has been identified in Australia and overseas (Buerhaus et al 2000; Dockery and Barns 2005; Drury et al 2008). The main reasons cited are a decline in young females interested in jobs traditionally seen as 'women's work' and expanding career options for females (Dockery and Barns 2005; ICN 2008; Staiger et al 2001). Many studies have identified the types of students who choose nursing, and what motivates and influences their decision (Boughn 2001; Dockery and Barns 2005; Larson et al 2003; Newton et al 2009). Although school leavers are attracted to DD programs (Batson et al 2002; Russell et al 2008) as yet, no study appears to have investigated why students enroll in a nursing

DD program or whether they take up a career in nursing after graduation.

### **Retaining new graduates**

Nursing shortages can negatively affect graduate transition programs and the experience of new graduates. To maximise employment options, the large majority of nursing graduates in Australia seek to undertake a graduate transition year in a healthcare facility of their choice. Hospitals generally have an official graduate transition or mentoring program that consists of the graduate rotating through wards or areas with support from a program educator, mentor or preceptor. Because of the insufficient numbers of experienced nurses who are able to take a mentoring role, many facilities have a limited capacity to accept new graduates. The difficulties associated with inadequate orientation to clinical areas and the lack of ongoing support in transition programs contribute to the high attrition of new graduates in that first year (Hayman-White et al 2007; Hegney et al 2002; McCabe et al 2005; Mills et al 2007; Newton et al 2009).

A further problem is horizontal violence in the form of aggression and marginalization by other staff members which is reported to be disproportionately directed towards new graduates (Hegney et al 2002; Lea and Cruickshank 2007). Blame for the high attrition rate is also attributed to universities because of the alleged unpreparedness of graduates (Crowley and West 2002; Kenny and Duckett 2003).

### **Retaining experienced nurses**

Experienced RNs report the inability to provide quality nursing care as the main cause of their dissatisfaction, burnout and decision to leave or reduce their hours of work (Hegney et al 2002; Hegney et al 2003; Morrow 2009). This inability is related to overwhelming workloads caused by the increased intensity of nursing activities and the increased acuity of patients serviced with no matching increase in staffing levels. The other reasons commonly given are the lack of autonomy, the inappropriate skill mix of staff and workplace violence perpetrated by patients, visitors and other staff (Aiken et al 2009; Hegney et al 2006a; Jackson et al 2003).

### **The changing nature of the nursing workforce**

Changes in the nature of the nursing workforce also contribute to the shortage of nurses. Almost one third (30%) of RNs are not currently in the nursing workforce (Preston 2009) and of those who are, almost half (48%) work part time (AIHW 2009; ANF 2006). Moreover, 49% of nursing graduates entering the workforce are mature-age (over 25 years of age), as previously mentioned, the age profile of graduates exacerbates the challenges associated with an aging workforce (Drury et al 2008; Gaynor et al 2007; Tindle and Lincoln 2002). Other factors include RNs changing careers (Kelly and Ahern 2008) and the 7% 'out' migration of the mostly young RNs to work and travel overseas (Preston 2009). Collectively, these factors lead to a net loss in the nursing workforce.

### **Expanding career opportunities outside nursing**

The growing labour market for nurses outside their traditional employment options also contributes to a loss of qualified RNs and warrants careful consideration in the context of the growth of nursing DDs. Technological advances mean more health services are provided at home and in the community (Swierisson 2009). As well, there are increased career opportunities and demands for nurses in generic management positions (ICN 2008). In addition, approximately 15% of nurses in Australia work in related occupations that are not officially designated as 'nursing' (Preston 2009). On the periphery of the healthcare system, for example, are early intervention programs such as *Families First* and *Brighter Futures* that promote the safety and well being of children and young people at risk (NSW Government 2009). While these programs do not require staff with nursing qualifications, a DD nursing graduate with the second degree in early childhood teaching is well qualified to work in these programs.

Restrictive and arguably outdated regulations that place artificial constraints on nurses' capacities to practice nursing outside traditional employment options may also exacerbate shortages. This problem is evident when nurses requalify in order to move into paramedicine in the ambulance services, another area that attracts nurses. RNs who wish to change



to paramedicine can do so relatively easily because they gain advanced standing in recognition of prior learning. Therefore RNs may fast track into a higher level in the ambulance service than paramedics in training with no prior qualifications (Reynolds and O'Donnell 2009).

DD graduates with qualifications in nursing and paramedicine may also work in the ambulance services. A study conducted in the Central West of NSW identified that the rural ambulance service would be keen to employ multiskilled nursing and paramedicine DD graduates but that within the ambulance service, DD graduates would be limited to working as paramedics (Hickey 2005). Regulations would prohibit them from using their nursing competencies. This anomaly could indicate that the healthcare industry may not be ready for these DD professionals. Regulations in Australia whilst protecting titles and professional autonomy on the whole do not allow cross professional care even though it could improve workforce efficiencies (Swerisson 2009).

### **The nursing education context**

Nurse education has seen a number of dramatic changes over the last 25 years. This section focuses primarily on the development of DDs in nursing against a backdrop of DDs in general.

### **Changes in the delivery of undergraduate courses**

In Australia as in many other developed countries the supply of nurses is inextricably linked with initiatives in higher education. While there are a number of different entry points eg. school leavers, enrolled nurses (Division 2), a Bachelor of Nursing (BN) degree has been the only pathway to becoming a registered nurse since nursing education was transferred from hospitals to tertiary institutions in the late 1980s (Russell 1990; Swerisson 2009). In an effort to make nursing courses more attractive Universities have become more flexible in their delivery of these courses by providing prospective students with many choices. Nursing students can now undertake part time study, distance education BN courses, online BN courses, enrolled nursing (Division 2) pathways, as well as DDs of varying lengths combining a BN

with another undergraduate degree. A search of university websites indicated that in 2008 there were 18 of these DDs on offer and in 2010 it had risen to 29. There has been an exponential growth in nursing DDs and the impact of DD students on Bachelor of Nursing programs and tertiary educators is unknown.

### **Who do nursing double degrees attract and why?**

As mentioned previously, we know little about the students who enrol in nursing DDs, or why they are attractive to them. Broader studies of DD students (i.e. across all discipline areas) indicate that DDs tend to attract a different type of student than do single degrees. DD students are more likely to have enrolled straight after completing high school (school leavers); their tertiary entrance scores generally are higher than the scores required for entry to equivalent single degrees; and there are more females than males (Batson et al 2002; Russell et al 2008). These studies indicate that students perceive the advantages of DDs as being a less costly and time efficient method of gaining an additional degree. They receive a reduction in completion time due to credits across disciplines and they gain a broader education with increased skills and options to those of single degree students (Batson et al 2002; Russell et al 2008). It would seem reasonable to assume that DDs that encompass nursing appeal to students for similar reasons, but in the absence of empirical data about nursing DD students, we can only speculate about who is attracted to a DD with nursing and the advantages seen. There can be little doubt, though, that nursing needs high achieving students and talented multiskilled professionals who are able to work across disciplinary boundaries.

### **RECOMMENDATIONS**

The issue for universities and the nursing profession is whether multiskilled nursing DD graduates are choosing to enter nursing or a role that involves nursing, or whether they are looking elsewhere. As this paper has highlighted, there are many other related, unanswered questions about DD nursing students and graduates. These questions are related to their dual career pathways. For example,

do students decide on their preferred career choice before they enrol? Do their experiences of studying by DD mode confirm or change their career preferences in relation to nursing? If they change their career preference during their university experiences is this important? What is it that makes them change to or away from nursing? Is there something that nursing is not offering that they desire? As graduates, do they look for work in one discipline area or in a position that combines the knowledge and skills acquired through their DD? Are they highly mobile in their careers, in the sense of wanting multiple career options and the ability to move between careers associated with their dual career pathway? Are they less likely to stay on a single career path? In light of so many unknowns, the paper concludes with two recommendations: 1) the need to obtain baseline data on DD nursing students and graduates; and 2), given the many unknowns about the career outcomes of DD graduates, the need to increase funded places for nursing education in Australian universities and relax regulations concerning cross professional employment.

#### **Obtain baseline data on DD nursing students and graduates**

As a matter of urgency, baseline data needs to be obtained on DD nursing students' characteristics, completion rates, graduate locations, career choices and retention rates as this is vital information for the future planning of the nursing workforce. Given that many cohorts are now graduating, it is timely to undertake investigations of DD students and graduates. While Graduate Destination surveys give an overall picture that DD graduates have higher employment rates and higher salaries as compared to single degree graduates (GDS 2008), they are not sensitive enough to give data on discreet DD combinations, such as nursing DDs. This is also true of the registering authorities in each State. Data is kept on numbers of RNs and those with post graduate degrees, but again these records cannot identify the specific numbers of DD graduates who register and are or are not employed as registered nurses. There is an urgent need for research that provides data on these students and graduates and insights into their career decision making.

#### **Increase funded places for nursing and relax regulations concerning cross professional employment**

Despite the increase in government funded nursing places in universities since 2002, the number of places still falls far short of the present and predicted industry requirements. With the increased intake of students including DD students there is an arguably unrealistic expectation that there will be more 'work ready' RN graduates. To take into account DD graduates who do not choose nursing, there needs to be an increase in Federal Government funded nursing places and more incentives for those who enter and remain in nursing. Additionally, there needs to be some relaxation of cross professional regulations and scopes of practice so that DD graduates can practice in both of the disciplines in which they have gained qualifications. If regulations were relaxed, these multiskilled graduates might not be lost to the nursing workforce; rather they would be seen as an asset.

#### **CONCLUSION**

In conclusion at a broad structural level the future focus on addressing nursing education, workforce planning, recruitment and retention strategies must take into account the significant presence of DD nursing students and graduates. DD students are filling undergraduates nursing funded places at Universities but if they choose not to do nursing after graduation this needs to be identified. Should this prove to be the case, in order for DDs to contribute to addressing the nursing shortage, targeted strategies will need to be developed to retain DD nursing graduates.

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# Nursing education: reducing reality shock for graduate Indigenous nurses – it's all about time

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## KEY WORDS

Indigenous Australian nurses, maximum clinical practice hours, reality shock, intensive theory delivery.

## ABSTRACT

### Objective

Since the decision to transfer nurse education to tertiary institutions in 1984, there have been many follow up inquiries to assess if the issues around training, including the inadequate preparation for the stresses of work, had in fact been addressed. This paper aims to highlight a range of specific strategies explored and implemented during the delivery of a Bachelor of Nursing program in an attempt to improve the retention of Indigenous nursing students and to generate a more enhanced educational preparation for future nursing students.

### Setting

Batchelor Institute of Indigenous Tertiary Education in Australia's Northern Territory and drawing on previous research about aspects of reality shock (identified by neophyte graduate nurses), that is; too much theory, not enough opportunity to practice clinical skills and insufficient mentoring.

### Subjects

Indigenous Australian nursing students studying at Batchelor Institute of Indigenous Tertiary Education campus, in Australia's Northern Territory between 2006 and 2008.

### Primary Argument

Ten years after the transition from hospital based to tertiary sector training, the 1994 National Review of Nurse Education in the Higher Education Sector, (presented by Reid et al), acknowledged that the undergraduate curriculum was constrained by the time demands required to cover clinical education and nursing subjects. The committee suggested that the (then) changing health care environment, and in particular the health care of Indigenous Australians, would necessitate an *increase* in time allocation in some schools of nursing lack of time should never be an excuse for failing to address student needs, such as the broadest possible exposure to, and repeated practice of, key clinical skills.

### Conclusion

A nursing curriculum focused on incorporating maximum clinical practice hours both on and off campus; limiting the time between translating theory into practice; implementing intensive theory delivery and developing a hospital based mentoring program provides solutions to reducing much of the reality shock experienced by new graduate nurses.



## INTRODUCTION

How to prepare neophyte nurses for the reality of working in hospitals has been an issue in Australia for over forty years. For example, the 1978 Inquiry into Nurse Education and Training to the Tertiary Education Commission that looked specifically at hospital based training, identified that classroom teaching and clinical teaching were frequently divorced, and there was inadequate preparation for 'the stresses of work' (Sax 1978). In 2002 the Australian Universities Teaching Committee (AUTC) nursing project by Clare et al, examined some of the *limiting* factors on the quality of clinical placement, one of which; the length of placement for students was considered too short to establish meaningful relationships between staff and students. The committee commented that 'these requirements for quality suggest that *more* long-term in-depth placements were required' including 'consideration for a breadth of exposure' (p. 128).

Additionally, in 2003 the AUTC identified several main areas of concern, one of which was the 'theory/practice gap- issues of relevance of some subjects and assessments and out of date or out of touch academic staff'. In terms of 'theory/practice gap issues': it was agreed this remains a high priority area including acknowledgment of the contribution of clinical. Best practice guidelines for clinical practice included dedicated learning environments and the use of preceptors and mentors (Clare et al 2003).

Mannix et al (2009) argued that all stakeholders (not just education institutions) have a role to play in contributing to 'optimising all the clinical learning experiences for students in Bachelor of Nursing programs'. This implies a wider group that would include the public, health professionals and particularly the education institutions and registration boards that have the responsibility of providing input during the development of nursing programs. Employers need a nurse graduate who can 'hit the floor running' and this can only be achieved through all stakeholders acknowledging recommendations that have been available for a decade.

There have also been various studies to highlight the issues surrounding nursing education and graduate preparation by independent researchers (Kramer 1974; Schalenberg and Kramer 1979; Kanitsaki 2002; Hinton 2003). This paper examines what has been learnt over a three year period after attempts were made to implement the findings of one such piece of research into an undergraduate Bachelor of Nursing course for Indigenous students at Batchelor Institute of Indigenous Tertiary Education (Batchelor Institute) in Australia's Northern Territory. This degree first gained accreditation in December 2005.

## DISCUSSION

### **The nursing program at Batchelor Institute of Indigenous Tertiary Education (Batchelor Institute)**

The main campus of Batchelor Institute is a small campus situated 97 kilometres south of Darwin in the small township of Batchelor. While the institution has other campuses, this is where the students in the program received their nursing education. Currently, Batchelor Institute will only admit and enrol Indigenous Australians into undergraduate programs. The students that elected to study nursing between 2006 and 2008, the period described in this study, were not that dissimilar from main stream university students and represented New South Wales, Queensland, Tasmania, Western Australia, South Australia, Northern Territory and surrounding Islands (Batchelor Institute 2006; 2009).

Some students were mature aged, many could have chosen to study their nursing at any university close to their homes and families, and while a minority already held other degrees or Vocational Education Training (VET) Certificates, some had completed year twelve while others had not completed secondary schooling. Ages ranged from 18 to 60, with both gender groups being represented, although the number of female students consistently outnumbered the males. A minority had long term relationships and small or adult children but most had comparable money, family, or social concerns as with those of main stream university students (Batchelor Institute 2009; 2006).

Throughout their years of study students were provided with accommodation, three meals a day and a discounted child care facility on campus. Students also travelled (free of charge) from every state, territory and island via aeroplanes, buses or boats, while those who chose to drive were reimbursed for fuel on the presentation of receipts. On clinical placement nursing students stayed in paid motel type accommodation and received on average \$300-\$400 per week travel allowance. Many students had applied for (independently) and were granted, scholarships and all received ABSTUDY<sup>1</sup> (or top up money if working part time). All students additionally received an additional up front \$400 book allowance.

Many of the students had come from communities and families where they had been exposed to many of the social ills – substance abuse, violence, socially dysfunctional people, and personal tragedy. Although some had worked full time prior to commencing studies, the course had a 100% mandatory attendance requirement for on-campus delivery. Due to the recency of this course online/external units were not offered. Some students had partially completed nursing studies at other universities and required recognition for prior learning (RPL) assistance and many needed assistance with scholarship applications. Many students faced challenges such as child care worries, and some had sick and/or dying family members back in their communities which impacted on the ability of some to concentrate, absorb information, and at times participate. Additionally, many students were mature women who were juggling their responsibilities regarding home, family, part-time work and study.

The strong sense of traditional family obligations shared by all Batchelor Institute nursing students, made design and delivery of the course more challenging. However, the luxury of small numbers (5-15) in each workshop meant more time could be spent providing each individual personal attention,

and therefore optimal learning experiences for students whether during clinical skills practice, clinical placement or during lectures.

### **The need for greater numbers of Indigenous Australian nurses**

Indigenous Australian health and education has been discussed and researched for as long as politics itself has been in existence (Indigenous Nurse Education Working Group 2002; Royal College of Nursing Australia 2004; Steering Committee for the Review of Government Service Provision 2005). It has also been widely documented that Aboriginal Australians continue to experience much poorer health than the general Australian population (Davis and George 1993; AIHW 2000) and it is acknowledged that improving Aboriginal health poses the greatest single challenge to the Northern Territory and its health care system (Northern Territory Government 2005).

This need to increase the number of Indigenous Australian nurses has therefore always been critical. In turn, this places pressure to provide both education and training that not only meets the challenges of recruitment and retention of nurses in general, but also to develop a program that meets the different and specific needs of Indigenous Australians as students. It also has to be a program that will not only enable them to work effectively within the diverse cultural needs of Indigenous Australians, but within our multicultural society as a whole.

The report of the Indigenous Nursing Education Working Group (2002) strategic framework identified four major objectives. Two of these worth mentioning here were to: 'increase the recruitment, retention and graduation of Indigenous students of nursing' and 'to promote the integration of Indigenous health issues into core nursing curricula in Australian universities within five years' (p 3). Batchelor Institute has an underlying philosophy of 'both-ways' that acknowledges this diversity and seeks to ensure Indigenous knowledge has a place in all programs delivered and the programs strengthen the identity of the students involved (Ober and Bat 2008). This was therefore an important aspect of delivery of the program.

<sup>1</sup> ABSTUDY (Aboriginal Study Assistance Scheme) is an Australian Government allowance administered by Centrelink available to Indigenous secondary or tertiary students or full-time Australian Apprentices, which may assist students/apprentices to stay at school or in further study.

### Previous research and how this influenced course delivery

Previous research completed by Hinton (2003) on mainstream new graduates from several state and territory universities within Australia, including the Northern Territory, indicated these new graduates of nursing felt unprepared to hit the wards running due to poorly developed clinical skills and time management (to name a few). Many indicated that lectures were lengthy and in topics quite useless to them once they were working. Many retrospectively commented some lecturers were out of touch with contemporary nursing and were not clinically current. The main theme noted throughout this research however was; 'too little clinical practice time' and 'too little clinical placement time within the hospitals'.

Worth noting is that while regulatory bodies such as the Nursing and Midwifery Board recommend as part of the requirements to gain registration, the *minimum* number of clinical hours required to be completed by students, institutions have the ability to set their own *maximum* clinical hours both on and off campus (Clare et al 2002). The Nursing and Midwifery Board of the Northern Territory recommend in the Standards for the Accreditation of Nursing and Midwifery Courses (p.24) 'a minimum 40-45% of total course time to be allocated to clinical experience in practice settings', and it should be noted that 'this experience does not include laboratory preparation'.

Another factor that must be taken into account when analysing the quality of the experience in practice settings is that nurses within the Industry were saying 'they were over worked, understaffed and felt they were being set up to fail as they had no time or device for monitoring/checking the students' ability to practice competently' (Hinton 2003). Ultimately, this contributes to graduate's decreased preparedness and increases what will be referred to in this paper as 'reality shock'

### Putting research findings into practice

The need for flexibility, the ability to set the clinical hours according to student needs, the students' strong sense of traditional family obligations and need to mitigate the factors contributing to 'reality

shock' were all taken into account during the design of the Batchelor Institute nursing timetable. A course timetable that had the least impact on traditional family commitments and one that essentially sought to reduce the impact of the factors that had been identified in the research as the cause of the - 'reality shock' for mainstream students. This meant; in terms of the latter - trying to achieve a minimal amount of time away from home and a maximum time spent practicing clinical skills both on and off campus while consolidating useful theory.

It also included a strong mentoring program, implemented through Batchelor Institute clinical facilitators. This consisted of two experienced and 'culturally aware' nurses working at the 'coal face' with students within their clinical settings and a third working in the nursing laboratory on campus. They were able to debrief the students on a regular basis and identify small uncertainties that could become large issues, discuss strategies for their resolve, and act as mediators when required. In the nursing laboratory, essential mentoring one-on-one was implemented; for demonstrating and practicing of clinical skills, developing time management and learning how to confidently communicate when sensitive patient issues arose.

The time table provided a week of intensive lectures covering a specific unit of theory, including contemporary nursing knowledge, Australian Indigenous knowledge, health history and nursing history. Students then returned home for one, two or three weeks, returning back to the Institute for another week of intensive clinical skills practice in the nursing laboratory immediately followed by one, two, three or four weeks of hospital placement (depending on the year level) to consolidate clinical skills and theory or as worded by Sax (1978) 'classroom teaching and clinical teaching'.

No student went on clinical placement without having first attended 100% of the week long skills practice in the nursing laboratory which concluded with students being signed off in their clinical placement manuals as competent or not yet competent. This manual not only formed part of the evidence of assessment for

the Institute, but was vital for busy industry staff when identifying at a glance the students' level of ability to practice safely. This week long practice immediately prior to clinical placement and with the use of a clinical placement manual as a constant guide, enhanced the development of the students' clinical skills including time management and confidence and as a consequence helped to close the theory/practice gap.

Current practicing registered nurses, job shared the clinical facilitator position for mentoring students and this meant students had immediate support in all clinical settings and for all shifts (including night duty). Facilitators could also follow up with students who had been identified as having limitations documented in their clinical placement manuals. In addition; the facilitators could continue to work part time in nursing a win-win situation for all, including those institutions struggling to meet demands on existing resources. All facilitators contributed greatly not only toward relieving the understaffed ward areas, but toward preparing nursing students for the 'real world'. The three current practicing nurses also guaranteed students were receiving contemporary nursing knowledge.

The teaching also included an approach on and off campus that sought to be as realistic as possible about what to expect in hospital settings, clinically, emotionally and socially. For example, the issue of racism was dealt with quite openly. Students were advised that they might encounter racism from colleagues and patients. This was dealt with 'we can all experience racism' and 'so what', and as for other social and emotional issues, all were given coping mechanisms. Life skills introduced were 'real' and useful to them, and were identified by students as tools that could be stored in their 'tool box' in order to deal with situations that may contribute to the 'reality shock' of life outside the safe confines of the institution. Throughout the three years of study it was emphasised that Australia is a multicultural society and all cultures needed to be mindful and respectful of each other as they delivered care.

### Lessons learnt

Batchelor Institute students responded to effective and efficient use of time provided by the timetable design. They had time to ask questions and opportunities to learn and demonstrate their knowledge and skills, whether during lectures, laboratory practice or clinical placement. While both their confidence and skills developed, they were made aware that this was just the very beginning and that nursing knowledge is obtained over a life-long journey, generally full of difficulties and diversions. The first most important lesson learnt was while time in a nursing program is limited, it does not have to be restrictive; it can be used creatively within a timetable so that students have time to ask, try and reflect.

Many larger institutions have time constraints driven by cost cutting and providing nursing training within budgets, however if this is disadvantaging nursing students to the extent that it is limiting time spent in clinical settings and without mentors, then this may be directly related to reality shock and contribute to student drop out. Although the Australian Government has the primary responsibility for funding and policy in the higher education sector, universities can distribute the funded load in response to demand or other priorities and are encouraged to respond to the needs of the nursing labour market as well as student demand (DEST and DoHA 2002). It would seem logical that the priorities of the institutions are in line with those that meet student and sector needs, but it is unfortunate that both do not realise what the needs are until they have graduated from the educational institution. It is therefore up to nursing course coordinators to be the protagonists for the students, and to follow up graduates responses to reality.

Follow up is also important given the continual changing nature of health care delivery and the range of challenges that new graduates will have to deal with. The education provided must have the ability to adapt to change and prepare newer graduates entering all the time with the ability to cope. If there is a continued erosion of the hours allocated for

clinical practice and clinical placement, this offers little opportunity to incorporate new directions and skills in one of the most 'hands on professions'.

Batchelor Institute was not only fortunate to be small but to also be able to provide financial and social support in key areas. While these assets may have made it easier for the students to attend nursing and succeed, they could be seen as levelling factors that made the majority of students equal to those in mainstream. While course content varied only slightly to meet the philosophical aims of the institution, the intensive teaching delivery, use of maximum clinical placement and nursing laboratory time and the unique time tabled workshops encouraged and provided the opportunity for the students to reach their full potential and become valuable members of the nursing profession. The mentoring program was also a crucial factor that contributed to the overall achievements of the students (both on and off campus), and to the program as a whole 'in collaboration far more is achieved than by working independently' (Brown et al 2005 p. 179).

## CONCLUSION AND RECOMMENDATIONS

The reasons that students remained in the course and succeeded at Batchelor Institute can be summarised as the unique time tabled workshops, relevant course content and delivery mode, intensive teaching delivery, and maximum clinical placement along with maximum nursing laboratory time. Effective use of time has been identified as the most crucial issue in all of these, for they enable the development of a most important attribute – confidence.

Further, this confidence was enhanced by having nursing facilitators mentoring students on campus and within the industry settings. For they not only provided wise, practical guidance in regard to the local nursing framework, but were continually creating learning opportunities where students engaged in the 'reality of nursing practice'. The mentors also enhanced relationships between Industry and Batchelor Institute and gave the nursing students' immediate support alleviating the doubts that can erode confidence.

Stakeholders, patients and staff within the Northern Territory Department of Health and Families and the private sector who supported student clinical placements and therefore provided a learning environment and experience that was as unique as the students themselves, are also recognised as making an important contribution.

The first nursing graduates in 2009 identified that they experienced no reality shock of nursing and that they felt clinically confident and competent in the nursing industry as a novice practitioner and therefore in order to produce Indigenous Australian nursing graduates who can 'hit the wards running' with reduced reality shock, it is therefore recommended that those providing the training consider identifying extra time for intensive blocks of work, particularly those that can provide clinical skills. It is also recommended that the maximum possible time is allocated for clinical placement, and time is found to include mentoring and discussion sessions with culturally sensitive nurses currently working in the industry who are willing to debrief and share their own experiences.

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# Nurse practitioners are well placed to lead in the effective management of delirium

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## ABSTRACT

### Objective

To acknowledge the detrimental impact that delirium continues to have on an individual and at the system level in an Australian acute inpatient setting and highlight the potential role that nurse practitioners can play in evidenced based prevention and management.

### Setting

Australian acute inpatient public hospital.

### Primary argument

Despite extensive literature and national policy driven initiatives delirium continues to be a neglected iatrogenic condition for elderly people. A local investigation by nurse practitioner candidates in an acute care hospital setting highlights the poor recognition of the problem. Delirium management must be a key part of the scope of practice for the gerontological nurse practitioner.

### Conclusions

Recognition and management of delirium is problematic. Leadership and continuity of care using evidence based prevention strategies; accurate diagnosis and treatment are important aspects of the gerontology nurse practitioners' (GNP) scope of practice.

## KEY WORDS

Delirium, Nurse Practitioner, Australia, Acute care hospital

## BACKGROUND

The role of the GNP is very new in Australia and to date has largely been explored in residential aged care (nursing home) settings (JBI 2007). At a regional hospital in north-eastern Victoria, gerontology nurse practitioner candidates (GNPC) are undertaking a clinical internship based in an acute inpatient setting and in the hospital administered community programs. These GNPC's have a scope of practice based on the geriatric syndromes (Tinnetti et al 1995; Fried et al 2001; Inouye et al 2007). As part of this scope they have developed an expertise in the diagnosis and clinical management of delirium under the mentorship of a visiting geriatrician.

In leading an improvement in the care of patients suffering from delirium the GNPCs investigated local prevalence data using an audit study by Speed et al (2007) for comparative values in the Australian health system. Close to 11% of 1,029 patients audited had a probable delirium but only 4 % were diagnosed as such.

The GNPC's undertook a medical record data audit of 4,008 episodes of care, of patients 70 years and over, from a one year period (2008) was undertaken at the sub regional hospital where they work. This audit showed an actual recognition level of delirium at 2.9%. Given that up to 60 % of people aged over seventy years admitted to hospital develop a delirium (Inouye et al 1999; Cole 2004, Olofsson et al 2005), this GNPC audit suggests that in the face of the lack of an active prevention and management program, this suggests that at a minimum, 75% of all deliriums, incident and prevalent, occurring in the acute care setting of this facility were not recognised. These findings reinforce the findings of Hare et al (2008a) and Speed et al (2007).

Despite evidence of a high delirium prevalence being published for a decade, it is clear that delirium remains an under diagnosed condition. This has far reaching implications for patients. It has a devastating effect on carers, a detrimental impact on the staff who struggle to provide safe care and on the health system which must cope with the provision of extra

bed days required by patients with delirium. Research suggests that health professionals regularly fail to differentiate between delirium and other cognitive changes in hospitalised patients. The GNP has a key role in ensuring that delirium is accurately diagnosed.

## INTRODUCTION

For an older person vulnerable to delirium an encounter with the inpatient health care system can be perilous. The noise, multiple staff, repeat questioning, invasive testing, bright lights, poor pain relief, pre procedural fasting, alien toileting and bathing facilities in addition to an exacerbation in a chronic illness or acute problem (which has brought them to the health service in the first place) is a major challenge to their mental well being. There is an urgent need to provide safe passage for these patients.

Clinicians trained in the specialist care of the older person are crucial to preventing the onset of delirium and to ensuring that patients with delirium are identified and treated. The interdisciplinary team can enable these patients to be well cared for through what is potentially a hostile environment if they have strong clinical leadership and are suitably skilled in the recognition of delirium and implementation of evidence based management. In a rural setting where geriatricians are at best an occasional sessional consultant, and nursing, allied health and medical staff must have generalist skills, the GNP can provide this kind of clinical leadership and maintain a continuity of expert care that ensures the older person receives a holistic approach to their acute health needs and reduces the incidence of delirium. The GNP is well placed to ensure that delirium is accurately identified and treated in accordance with an evidenced based approach.

## Definition

Delirium is a short term disturbance of consciousness which lasts for as little as a few hours to as much as a few months (Marcantonio et al 2003; Inouye et al 1999b). Disorientation, problems with memory, thought, perception, and behaviour of an acute onset

and fluctuating course are hallmarks of the condition (Cole 2004). Delirium can manifest as hyperactive, hypoactive, or a mixture of both.

### Prevalence

Many studies have examined the prevalence of delirium in the acute inpatient setting. The incidence of delirium has been reported at 7% to 9.6% on presentation to the emergency department, with the incidence in patients admitted to the medical units being as high as 15% - 20% and a further 5% - 10% of patients developing delirium during their hospital stay. Surgical unit patients have a higher incidence at 15% - 53% post operatively, with the greatest incidence found in the intensive care unit, where registration of delirium is 70% - 87% of patients. (Siddiqi et al 2007; Cole 2004; Inouye 2006). Despite this delirium remains poorly recognised as a serious comorbidity for elderly patients in the acute inpatient setting.

### Diagnosis

While many people who develop delirium have a pre-existing dementia, delirium is often not detected or is misdiagnosed as dementia or other psychiatric illness even though there are potential strategies to differentiate between dementia and delirium (Cole 2004). Nursing and medical staff fail to recognise and diagnose delirium in over 70% of cases (Marcantonio et al 2002) and the reasons for this are multiple and often complex (Inouye 2006). Bourgeois and Seritan (2006) and McCarthy (2003) have stated that the heterogeneous nature of delirium is contributory to a poor rate of diagnosis. They opine that it is commonly misattributed to dementia or as the natural progression of ageing and its association with inevitable cognitive decline. Alternatively, a hypoactive delirium often results in a diagnosis of depression (Inouye et al 1999a). It was reported in one study that over 40% of patients referred to a consultation liaison psychiatrist for assessment and management of depression were ultimately found to have delirium (Marcantonio et al 2002).

As has been observed by Inouye et al (2001) that hyperactive forms of delirium were more likely to be diagnosed than those with a presentation suggestive

of a hypoactive delirium. Understandably the former group created greater demands on staff than the latter and subsequently were noticed.

The causes of delirium are multifactorial. Predisposing factors when influenced by precipitating factors complete a stress-diathesis model (Attard et al 2008), thus triggering delirium. The recognised risk factors, as expressed by Linton and Lach (2007), Capezuti et al (2008) and Millar (2004) are advanced age, visual and hearing impairment, previous cognitive impairment, medical comorbidities, functional impairments, depression, medication use such as benzodiazepines, psychotropics and anticholinergics and prior alcohol abuse.

Precipitating factors are insults caused whilst in hospital. These include, the addition of three or more medications, iatrogenic events such as – a bladder catheter, physical restraint, malnutrition, dehydration, care-setting relocation (high incidence in critical care), electrolyte imbalance and infection, and pain.

Despite the presence in Australia of evidence based guidelines and algorithms (AHMAC 2006) to assist in the diagnosis of delirium the reality is that in the busy hospital environment the imperative is rapid processing of people to facilitate minimum wait times and meet capacity targets (Bezzant 2008). Nowhere is this more evident than with elderly people at risk of delirium. The complex cocktail of acute and chronic physical and mental health that is present in the elderly requires highly skilled assessment and care planning but is usually attended to by the most junior members of the medical team.

### Patient outcome

Maher and Almeida (2002) regard delirium as a medical emergency. It has the same morbidity and mortality as sepsis and myocardial infarction (Mandal and Nasim 2007), yet patient management, pathways and recourses differ greatly.

Mortality associated with delirium is high. Inouye et al (1999a) has found that the development of delirium in the acute hospital environment is associated with mortality rates of 25% to 33%. It has been estimated

that the one and six month mortality rate of delirium associated death to be 14% and 22%, respectively, which is approximately twice that of patients without delirium (Cole and Primeau 1993).

The leading complication of hospitalisation for older persons is functional decline (Vorhies and Riley 1993) occurring as early as the second day of admission (Hirsch et al 1990). Functional decline can manifest in the development of delirium and contribute to a number of adverse outcomes, including pressure areas and falls with subsequent injury such as fractured neck of femur (Hirsch et al 1990).

Empana (2004) contend that hip fracture is associated with a 14% - 36% risk of death in the first year and persists for several years after. This must be considered in conjunction with the effect on mortality just from the incidence of delirium alone (Inouye et al 1998). Delirium can result in functional and cognitive decline both in the short and long-term. The short-term repercussions centre on increased length of stay, complications and patient injury (Cole 2004). The long-term repercussions are associated with decreased quality of life and loss of independence as functional and cognitive impairment can persist for at least one year (Siddiqi et al 2007). Delirium results in increased rates of admissions to long-term care facilities (Cole 2004; Marcantonio et al 2003).

#### **Effect of Delirium on families and hospital staff**

There is good evidence of the burden delirium imposes not only on patients but on those who care for them. O'Malley et al (2008) examined the literature on the experience of delirium from the perspective of patients, families and staff. Families reported their distress at seeing their loved one in a delirious state and many felt there were deficits in the medical care. Staff emphasised the issues of workload and their problems in resourcing the needs of all patients when the hyperactive delirious patient was so needy of nursing time.

Harrison and Zohhadi (2005) elicited four key themes in their focus group study of issues which affect the optimal care of the elderly patient with mental health problems in the acute hospital ward.

These were: 'disruption'; 'role conflict'; 'professional resources'; and 'professional distress.' It could be logically surmised that there is a resulting burnout and absenteeism that accompanies such an occupational experience for staff.

#### **Ageism as a culture**

Some of the central reasons for the poor management of delirium include a global knowledge deficit and a health culture that refuses to prioritise the elderly, cognitive impairment and the impact of this at the personal and community levels. Inouye et al (1999a) state that medical and nursing staff spend less time with patients over the age of 65 years. This occurs for a variety of reasons, which includes cultural or societal attitudes toward the care of the elderly. Kane (2002) documents the significant research, which has occurred in the areas of practitioners' attitudes toward older people together with professional gerontological knowledge. This reported literature suggests that on the positive-to negative attitude continuum, health professionals' attitudes to older people falls toward neutral to negative. Poor attitudes, coupled with a gerontological knowledge deficit amongst the current acute hospital health team, does not bode well for the care of the elderly patient.

#### **System Effect**

Not only does the failure to recognise the diagnosis as important correlate to an under appreciation of its clinical consequences (Inouye 2006), it has serious detrimental effect on an acute health organisation. Burgeoning costs and an increasing utilisation of the health care system by an ageing population further highlights the importance of the prevention and minimisation of delirium in the acute care setting.

Delirium in elderly acute hospital patients has been associated with longer hospital stays even in analyses that control for severity of medical illness. Delirium is also associated with higher hospital costs and greater likelihood of placement in a nursing home at discharge (Savaray et al 2004). The cost of delirium to the healthcare system is substantial. In the United States of America for the year 2004, Inouye (2006) estimated that delirium complicated hospital stays for over 2.5 million patients over the



age of 65 years amounted to an extra \$6.9 billion of hospital expenditure. Although there is some local data as to how the length of stay is impacted upon by delirium (Wong Tin Niam et al 2009), Australia contributes only a small portion to the overall body of the research into delirium, with no current Australian costings available (Ski and O'Connell 2006).

Delirium management outside a structured intervention program generates its own risks and can contribute further comorbidities up to and including sentinel events. The GNP's noted in their audit work described earlier, that in the period of one week, four incidents of a fall in patients with undiagnosed delirium resulted in a fractured neck of femur. Not only do these preventable occurrences impact on the facilities ability to deliver health care to the community, it also further impacts on the patient's prognosis.

The impact of an unrecognised delirium on the patient notwithstanding, there remains a level of unrealised income for a complicated service rendered. The funding model for acute health services in Victoria, Australia follows the recognition of diagnosis related groups (DRG's) with delirium coded as a comorbidity, which has a contributory factor in addition to the DRG base funding amount. A comorbid delirium not only increases the length of stay (McCusker et al 2003), but without adequate clinical recognition and documentation, financially undervalues the care delivered during the admission.

#### **Nurse practitioners as the lead clinician in the detection and management of delirium**

Delirium is potentially preventable (Mandal and Nasim 2007). In recognition of this and the personal and public cost of delirium in Australia there has been a strategic push from government to address this issue. The Council of Australian Governments long stay older patients (COAG LSOP) initiative commenced in 2006 (AHMAC 2004) is informed by both State and Commonwealth policies such as 'Improving Care for Older People' (Vic. DoH 2010), 'Care in Your Community' (Vic. DHS 2006) and 'Rural Directions for a Better State of Health' (Vic. DoH 2009). The current focus of the COAG LSOP initiative includes the

launch of a resource tool kit to health services across Victoria that will aim to minimise functional decline. The information contained in the tool kit builds on previous work undertaken and uses evidenced based consensus guidelines (AHMAC 2004; AHMAC 2006). Welcome as these resources are, on the ground clinical drivers are crucial to their success.

In the case of delirium awareness, education is vital for prevention and recognition but crucially a diagnosis of delirium needs to be made, documented in the medical history and treatment initiated. The GNP's, as expert clinicians with extended skills in diagnosis, prescribing and referral are well placed to lead, maintain momentum and be accountable for delirium prevention and management within the interdisciplinary team across the acute care health system and into the community.

Clearly from the local audit undertaken by the GNPCs there is a failure to proactively and routinely assess cognition which is vital for early detection of delirium. As a response the GNPCs are evaluating and improving the Risk Assessment completed on admission to include every patient over 65 years. Global risk screening within the first twenty-four hours, carried out by the admitting staff may assist in the identification and differentiation of delirium. Screening questions for all gerontology syndromes can assist with early identification of delirium and referral for specific and comprehensive assessment. Specific assessment may include, but not be limited to the Confusion Assessment Method (CAM) (Inouye et al 1990) and the Abbreviated Mental Test (AMT) (Jitapunkul et al 1992) to give an initial guide as to whether a patient has a cognitive impairment and would be at risk of developing a delirium. In line with findings of Hare et al (2008b) the emergency department is a key area for early and accurate assessment and has been targeted by the GNPCs.

McCusker et al (2003) emphasises that it is only through a planned program of delirium screening, prevention, detection and management that hospitalisation will be minimised and outcomes maximised for elderly patients. The GNP is well placed to do this. Highly developed assessment skills,

the capacity to prescribe appropriate medications and advise physicians on risks and advantages of particular drugs while older people are hospitalised mark the GNP out as a key driver for better outcomes in regard to delirium.

Subsequent to this audit a prospective study is being planned with a GNPC intervention. In addition at this particular rural setting, the GNPC's are exploring the concept of a shared bed card with surgeons or physicians and the GNP which would enable the GNP to take a lead role in the areas of care specific to comorbidities of the elderly and in particular delirium. The GNP is taking an important role in delirium education and local clinical research for the broader interdisciplinary team.

## CONCLUSION

Delirium in older patients within the acute health setting has a high prevalence and incidence. It can significantly reduce the quality of life and independence of its victims both in the short and long term which in turn has serious financial ramifications for the health system in general.

Despite the known outcomes for delirium, it remains an illness that is not well managed for a variety of reasons including poor diagnosis, culture, attitudes and resources.

The distribution of national evidence based guidelines is a step in the right direction but with the pervasive culture of ageism in a system, staffed primarily by junior clinicians and driven by rapid assessment and throughput, delirium will continue to be a major problem. GNP's have a powerful role to play in consistent diagnosis, acute and long term management of these patients. There is an important role for them in delirium education and research. In addition accurate diagnosis will generate an income stream that can meet the costs of specifically tailored delirium management.

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# Scope of emergency nurse practitioner practice: where to beyond clinical practice guidelines?

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## KEY WORDS

Emergency nurse practitioner, scope of practice, clinical practice guidelines, fast-track

## ABSTRACT

### Aim

The aim of this paper is to discuss some of the issues around continuing development of the Emergency Nurse Practitioner (ENP) role in a Victorian metropolitan Emergency Department (ED) setting. More specifically the discussion will consider the evolving clinical practice of the ENP in relation to clinical practice guidelines (CPG) and optimal utilisation of ENP skills and expertise.

### Background

Internationally the mainstay of ENP practice is predominantly minor injury/minor illness models of care. This trend reflects traditional areas of need, or service gap. It is recognised however, that for a service

to be sustainable and effective, it must be flexible, dynamic and prepared for future challenges.

The development of CPGs to inform 'scope of practice', has become contentious. The restrictive nature of ENP specific guidelines has become evident over time, and together with the labour intensive nature of their development, continuing use is questionable. The trend towards the use of multidisciplinary clinical practice guidelines that utilise existing clinical protocols has gained support for future nurse practitioner (NP) role development. These guidelines are generally of a robust, evidence based nature, with regular review and update and don't apply to any specific clinician group.

### Method

An exploration of the progression of the ENP role and service model at a large metropolitan hospital ED was undertaken. An examination of the ongoing changes in demand for ENP service within this organisation was carried out together with the strategies in place, or required, for ENP role expansion and flexibility.

### Setting

The setting for this discussion is a large metropolitan Emergency and Trauma centre in Melbourne, Victoria, Australia. The ENP team consists of endorsed ENP and those in training, generally referred to as Emergency Nurse Practitioner Candidates (ENPC). This ENP/C team is employed and cover sixteen hours per day, seven days per week, primarily in the 'fast-track' area of the department. 'Fast-track' is an area within the ED specifically treating patients presenting with minor injury and minor illness deemed likely to be seen, treated and discharged within a four hour time frame.

### Conclusion

The ENP model of care at this organisation confirms ongoing evolution and expansion of the role in terms of increasing numbers of ENP/C. Questions continue as to the most efficient utilisation of the role to best benefit the ED as a whole and more specifically, patient outcomes. The need for a continued, cooperative and collaborative approach by stakeholders to inform role progression and continuing clinical practice expansion is paramount for continuing department improvements and better patient outcomes.



## INTRODUCTION

The NP role in Australia is a relatively new one with the first NP endorsed to practice in 2000, in New South Wales (NSW). Currently there are over three hundred and fifty NP's endorsed to practice nationally in a variety of specialties (DoH 2010). In comparison to the international position, the numbers are small, but growing consistently with increasing awareness. The success of the NP role is well documented in international and national literature, with NPs providing care in primary and acute care settings (Wilson et al 2008, Jennings et al 2009, Carryer et al 2007, Cole and Kleinpell 2006, Christofis 2001).

The NP role is dynamic and flexible, responding to demands in patient services, and identified gaps in service provision. The ENP role is a proven model of care and is becoming well established in Victorian ED's with a total of 22 ENPs representing approximately 40% of the total Victorian NP numbers, and an unknown number of ENPC preparing for endorsement (DoH 2010). Recent literature is consistent with international findings whereby a high level of satisfaction with this model of care is reported (Jennings et al 2009, Thrasher 2008, Hayes 2007, Davidson and Rogers 2005).

An important issue facing NP's is how to define the 'scope of practice' and how the evolving nature of this practice is determined and described from a clinical perspective in terms of boundaries for practice. The Australian Nursing and Midwifery Council (ANMC) have published a set of competency standards that are accepted as the guidelines upon which practice is based and measured (ANMC 2006). Despite these competency standards which form the acceptable overarching professional standards by which to benchmark the role, clinical variations in ENP roles are evident at the organisational level and further structures are required to inform practice in the clinical setting. The emphasis of NP scope of practice must retain flexibility to ensure essential responses to changes in the health environment. As with other nursing roles, a clinical role which incorporates innovation and dynamism, able to address future challenges of patient care is what the NP role aims to achieve.

In the current setting, discussions have taken place to determine what is expected of the NP role clinically and professionally. Gaps have been identified in relation to how the NP fits into the organisational structures currently in place, in terms of defining what constitutes scope of practice in a changing and evolving role. More specifically, this position relates to determining what the ENP can and cannot do, which patients can be seen, and the medico-legal aspects of clinical practice. This work adds to the literature by providing an introductory discussion around the basic requirements needed to formulate an organisational framework and policy direction for ENP practice.

## Background

The development of the NP role, both nationally and internationally, has been politically influenced as a result of the challenges to meet increasing healthcare demands. There have been arguments which laud harnessing the wealth of knowledge and practice experience that nursing brings to healthcare (DHS 2004a), whilst others detract from the quality and expansion of this nursing input (AMA 2005, RACGP 2010, Cree 2009). Despite these differences of opinion, the challenge to improve patient access and equity whilst maintaining a focus on patient outcomes remains a priority.

The ENP role was initially informed by increasing numbers of patient presentations to ED leading to overcrowding and lengthy waiting times. This increase in demand is a position consistent across Victorian and international ED's (Fry 2009, Campo et al 2008, Wilson et al 2008, Davidson and Rogers 2005). As a result of increasing demand on existing services, patients began to experience lengthy periods of 'time to be seen', with management, diagnoses and subsequent discharge times becoming excessive (Barr et al 2000). The ENP model of care initially began with a solid mandate to address the needs of those patients waiting excessive periods in ED waiting rooms.

The ENP role initially sought to address the needs of patients presenting with minor illness or minor injury. These patient presentations were generally assigned



an Australasian Triage Score (ATS) of four or five after triage. The ATS is a clinical tool used in many ED settings to ensure timely patient management according to clinical urgency (ACEM 2009).

Given the innovative nature of the ENP role and the lack of local precedence for its development at commencement in 2004, a decision was made by the Victorian Government DHS following a recommendation by the Nurse Practitioner Implementation Advisory Committee (NPIAC) to produce Clinical Practice Guidelines (CPGs) (DHS 2004b). The CPGs were developed by the individuals working in the role and they directed the clinical practice of ENP/C at commencement of their role. The guidelines framework indicated that they should “address specific clinical presentations” and aim to provide guidance to “the nurse practitioner in clinical assessment, clinical management, referral processes and clinical evaluation.” (DHS 2004b pg 15). The NPIAC recommendations also suggested that the CPGs form part of the endorsement process, through the Nurses Board of Victoria (NBV).

At the Alfred Emergency and Trauma Centre (E&TC) twenty five CPGs have been developed to guide the ENP/C role. These CPGs form the basis of clinical practice for the ENP/C including minor injuries such as fractures, sprains and strains, and minor illness such as urinary tract infections and deep venous thrombosis. The diverse nature of ED presentations, together with increasing numbers presenting for primary care, has raised questions about ENP specific CPGs as an outmoded method of clinical definition. The number of hours devoted to their development and the need for ongoing reviews and updates has proved cumbersome. The expectation of writing a guideline to cover ‘Nurse Practitioner’ specific management of each patient presentation is unrealistic. The guidelines assisted the initial role structure and development, and continue to achieve this for beginning ENP candidates, a more acceptable approach is now needed.

The use of protocols or multi-disciplinary guidelines to inform practice, ensure standardisation of clinical treatment regimes and outcomes, is not to be

rejected. However the development of ENP specific guidelines over and above existing multi-disciplinary documents is unreasonable. Guidelines to provide comprehensive information on the patient care continuum for a variety of clinical specifications, and clinician groups which allow for clinical judgement are more appropriate for the direction of patient care into the future. The argument for initially defining ENP scope of practice around single practitioner ENP guidelines, for particular presentations is restrictive and one which impedes flexibility and progression. Consequently the development towards multidisciplinary guidelines for standardisation of clinical regimens seems a more acceptable approach.

A large part of the success of the ENP role at the Alfred E&TC is attributed to the increased ability to maintain improvement in measurable Key Performance Indicators (KPIs). These KPIs have been set by DHS, such as see, treat and discharge >80% of non admit patients within four hours of arriving to the ED (DHS Vic 2008). Following an increase in the number of ENP hours at the Alfred E&TC, this 80% target has come it’s closest in many years despite increasing numbers of patient presentations. Whilst it is recognised that there may be other factors contributing to this improvement, it is acknowledged by Alfred E&TC management that the ENP/C group have made a positive impact.

A reduction in the number of patients who ‘did not wait’ (DNW) ie left prior to treatment commencing – has also been achieved (Lee and Jennings 2006). These results are significant from a risk management perspective, due to the risk of adverse outcomes for any patient who leaves the department without adequate treatment intervention or advice.

It is important to note that Jennings et al (2009) report a high level of patient satisfaction has been achieved in addition to the improved financial outcomes. Further, the competence of NPs to manage patient care in a comparable manner to physicians, with high levels of patient satisfaction combined with increased advice on education, health promotion and follow up advice has been well reported in the international

literature (Chen et al 2009, Jennings et al 2009, Phillips 2007, Barr et al 2000, Chang et al 1999). It is essential to emphasise this human perspective whilst acknowledging that the ENP role remains firmly entrenched within a nursing framework. The ENP role enables the provision of a holistic approach to patient care including patient education and follow up advice, all reflective of a nursing philosophy (Lee and Jennings 2006, Shapiro and Rosenberg 2002, Christofis 2001, Maurice and Byrnes 2001).

Currently at the Alfred E&TC, the ENP/C group together with management and other multi-disciplinary groups are considering the next steps in ENP clinical practice. The goal will be to develop terms of reference for the clinical role of the ENP without reliance on ENP CPGs. Development of a framework is required in order to match ENP clinical practice to departmental needs and appropriateness of clinical knowledge and skill of the clinician groups. This framework must be cognisant of aspects of patient safety and organisational responsibility, whilst allowing flexibility and change to occur as needed.

## DISCUSSION

### Current scope of practice

The current scope of practice of ENP at the Alfred E&TC continues to be based upon the original Model of Care (MoC) document which is the overarching local governance of the ENP model, restricting ENP practice to CPGs. Under the model, the ENP/C are not permitted to manage patients outside the scope of the CPGs independently. If an ENP (endorsed) assumes management of a patient who falls outside an existing CPG, the ENP then works within a collaborative model for continuing patient care. Various collaborative models are discussed in the literature, but for the purposes of this setting, collaboration is a means of ENP verifying management and treatment strategies for patients under their care, falling outside the existing CPG model, with a senior medical staff member.

At present there are a number of patient presentations to the ED that are considered ENP appropriate, but

not within existing CPGs. The increasing ability of ENPs to function well under the minor injury/minor illness model, creates a situation whereby other patients groups falling outside the CPG model continue to experience delays and extended waiting periods for treatment. Dawood (2000) and Christofis (2001) also report a similar pattern whereby patients presenting with minor injury/illness are treated more efficiently by ENP's than those presenting with emergent conditions waiting for treatment by a medical officer.

This reflects a situation which in part fulfils the intended purpose, but leads to a gap in service delivery due to restriction on ENP scope of practice. Davidson and Rogers (2005) conclude that an overly restrictive framework for practice scope, limits the benefits of the NP role. The CPG model of practice it is argued, is restrictive and raises an important issue around appropriate utilisation of human resources within the healthcare setting.

An opportunity exists to address continuing gaps in service in order to provide better patient outcomes, particularly in terms of waiting times in the ED. Recent data collection undertaken at the setting of this large metropolitan hospital ED, suggests that ENP activity is not governed by CPG's in approximately 35% of cases (Grummisch et al 2008). This reality highlights the need to consider other approaches to define what it is that ENP's could and should be achieving in this ED setting.

The latest data, as seen in table 1, shows the variety of patient presentations seen by ENPs outside of CPG scope and reflects in part the ongoing evolution of the ENP role and the clinical need for flexibility (Grummisch et al 2008). The results in table 1 reflect some of the changing patterns in ED patient presentations from the original CPG model, and the changing environment in an ED setting. It is argued that an approach other than continuing development of ENP CPGs is required to determine ENP scope of practice within this environment. A more flexible approach is required to ensure equity in service provision for a variable population group.

**Table 1: Non CPG patients seen by ENP.**

Presenting complaint	Total
Eye injury/foreign body	68
Abscess	54
Allergic reaction	30
Asthma/COAD	5
Back pain	40
Bite - non venomous	17
Catheter change	9
Chest pain	17
Dental pain	15
Epistaxis	8
Foreign body	76
Genito-urinary misc	17
Headache	13
Injury – thorax	37
Misc.	38
Musculo-skeletal unspecified	68
Neurovascular unspecified	7
Osteomyelitis	2
Palpitations	3
POP problem	37
Post op complication	68
Present for diagnostic tests/results	30
Present for inpatient review/admit	31
Present for script/medications	26
Rash FI	43
Social/psych/drug and alcohol	32
Wound management (not injury/post op)	149

This data indicates that clear definition of the NP role is not always apparent, a finding which is also reported by Chakravarthy (2008). To date, in order to maintain optimal use of the ENP group, the extended range of patient management has been achieved through a collaborative model of care. Although collaboration continues to play a large part in ENP practice, as with all nursing roles, this process undermines the utility and clinical judgement of ENP in many instances.

#### **Future direction**

The ENP role was implemented five years ago into the Victorian hospital ED setting. In this current setting, the role has been successful in terms of patient satisfaction and improved outcomes (Jennings et al 2009, Lee and Jennings 2006). It is timely to

question the organisational structure required to inform continuing expansion of clinical scope of practice to replace the CPG model. This challenge is similarly reported by Cummings et al (2003) in their evaluation of an NP role, and raised by Dawood (2000) in regard to the under utilisation of ENP skills.

The NBV have a publication which clearly articulates the requirements on governance regarding professional scope of practice issues for all registered nurses (NBV 2007). These guidelines are adopted from a previous work on National Competency Standards for the NP which has been endorsed by the ANMC (ANMC 2006). In Victoria, issues of ENP practice are sanctioned by the employing organisation and the setting in which practice is undertaken. In essence, the future direction involves looking at how to continue role development in a manner that continues to meet organisational needs, together with those of patients/families, and nursing professionalism. Consideration must be given to the most constructive and effective means of providing:

- care for patients who fall outside the existing CPG model;
- a flexible ENP model of care which allows for natural evolution in response to patient needs;
- satisfactory clinical support for ENPs providing increased services;
- clinical and professional development to meet the needs of ENPs; and
- a definition of ENP clinical practice which provides role clarity.

Each organisation, when considering establishing an NP model of care, is expected to have in place a framework which addresses issues of expanding scope of practice, including risk management, stakeholder consultation and service needs (NBV 2007). As stated previously, the adopted framework in Victoria was based on a recommendation for CPGs to be developed, and there is no evidence in the literature to describe a variation on this framework in other Victorian ED's. The challenge

is to develop a framework which encompasses changes to NP practice as the roles evolve, as healthcare requirements change or as numbers of NP hours increase to change the workflow patterns. It is proposed that ENP's could, in fact, intervene in the care of a broader range of patient presentations than currently undertaken (Cole and Kleinpell 2006, Davidson and Rogers 2005).

With an increase in the provision of the ENP service and a proven ability with current patient groups, it is judicious to consider advancement of the ENP role beyond the 'minor injury/minor illness' model which informed the initial framework. Initially the ENP framework in the minor injury/illness model was the result of an evaluation of the most common presentations to the ED. The model was built upon these presentations to guide initial education, experience, knowledge attainment, and of course access to care. It was not designed to solely define ENP care but as a platform from which ENP care could become sustainable, progressive and efficient.

Risk stratification begins at triage, risk re-stratification begins with timely patient assessment by a nurse/medical practitioner with initiation of appropriate diagnostics and/or interventions. Subsequent evaluation with decisions regarding management and treatment are also necessary to continue the patient journey in a timely fashion. The expansion of ENP scope of practice to enable diagnoses, management and disposition plans for a variety of patient presentations, combined with appropriate consultation with senior medical staff as required, should see benefits to a larger proportion of patients. As stated, the patient population is not static and experienced staff should be utilised in the most efficient manner. This includes drawing from the vast experience and knowledge base ENP have, first as senior nurses, who have built upon this clinical ability.

There is an abundance of literature available discussing NP role development, role progression, education and scope of practice issues. To date, these works reveal an inconsistent development of NP roles internationally and therefore an inconsistent

definition of scope of practice in the clinical arena (Carter and Chochinov 2007, Howie-Esquivel and Fontaine 2006, Cole and Ramirez 2005, Gardner and Gardner 2005, Gardner, et al 2004, Cole and Ramirez 2000, Sherwood et al 1997). Despite these differences, the introduction of NP's into the acute care setting has gained merit and acceptance, and although flexibility is required to reflect various settings, it remains a vital component of framework development that transparency and legitimacy of practice are validated.

### **Exploring framework development**

Evidence suggests that in the current setting ENP's are capable of delivering care and clinical management to patient presentations over and above the existing CPGs (Grummisch et al 2008). With increasing demands for service, broader coverage of the ED by ENP/C and positive impacts on the KPIs of the original target groups of minor injury/illness, it is time to deliberate on the next stage of development of this model of care. Statistics drawn from departmental databases at the Alfred E&TC suggest that expansion of the role is imperative for ongoing ED patient management. The Alfred E&TC has experienced an overall increase in patient presentations representing all ATS categories one – five. It is anticipated that for ENP/C to continue to service areas of most need, their evolving clinical scope of practice should continue to progress. This will ensure other practitioners are better able to meet the needs of more complex patient groups (Wilson et al 2008) and impact ED management as a whole. The challenge is in the organisational direction this should take in order to define and otherwise characterise the evolution of this role in order to widen the impact.

As Masters prepared clinicians, NP's are taught not only clinical knowledge and skill, but also develop solid foundations in critical thinking. The development of a framework for future ENP practice which acknowledges their educational preparation and professionalism is expected. A framework which recognises ENP potential and ignores cumbersome and unnecessary restrictions, such as ENP specific CPGs, is more likely to provide benefits by meeting

changing organisational/healthcare needs. This requires a dynamic perspective with management support, continued multi-disciplinary input and willingness to advance the NP model of care aimed at enhancing the capability of the health care system. Organisational service needs and requirements, ongoing educational and professional development requirements, professionalism, leadership and clinical governance issues must all be addressed. These issues are also discussed in the United States of America literature, whereby the various levels of governance for NPs and their clinical scope of practice are discussed (Hravmak et al 1996). The difficulties faced by organisations when credentialing NPs for scope of practice in individual settings are also discussed (Klein 2008).

It is argued that ENP/C in this ED setting are in a position to expand the service model they provide. Building on a number of clinical governance that processes are in place to address issues of ENP/C competency and safety of practice can inform the development of the framework for expanding ENP practice. Until now, the Scope of Practice committee at the Alfred had not had sufficient processes in place to deal with the issues around extensions to practice that exist for NP's, such as prescribing medications, ordering diagnostics and admitting or discharging patients. These processes are now under review in order to keep pace with the evolving ENP role which outgrew the original framework, based upon CPGs.

As well, ongoing education has continued with the ENP/C attending weekly structured education sessions with the ED medical staff. Other more specific ENP/C education sessions are organised, addressing self identified gaps in knowledge and skill, as well as fulfilling ongoing professional nursing development needs. Once a needs analysis has been assessed, the sessions are presented by a variety of multi-disciplinary health care professionals. Presentation of case studies by the ENP/C group and discussion of clinical scenarios incorporating a holistic approach to care has continued to encourage sharing of knowledge and to enhance problem solving skills.

The ENP/C group at the Alfred E&TC are diligent in reviewing their clinical practice. They review diagnostics which they have ordered in the management of patient care, together with outcomes and follow up where possible. This involves reviewing x-Ray, pathology and other results, to ensure appropriate management plans and follow up are in place. In pursuing the review activities, ongoing professional development is supported whilst encouraging reflective practice. The current review practices will continue as professional development and evaluation strategies for any proposed changes or expansion to scope of practice.

One of the ways in which confidence, competence and ongoing skill management is supported, is in the multi-disciplinary mentor relationships within the department. Individual ENP/C are assigned a ENP mentor as well as a medical mentor on commencement in their role. These relationships are encouraged, with frequent and regular meetings expected. The meetings allow discussion of relevant issues, both clinical and professional and supports the advantages of the ongoing collaborative model of care which exists between ENP and medical staff.

Given the existing collaborative model of care which has evolved across the ED, development and growth of ENP scope of practice beyond current CPGs is the obvious next step. The expanded clinical practice will follow a structured approach according to organisational needs. Suitable target patient groups will be identified through existing department databases. This will guide the development of focussed, clinically based learning needs to ensure ongoing maintenance of competence. A credentialing process will be formalised, with subsequent analysis to provide ongoing information and evaluation of clinical outcomes and ongoing patient satisfaction.

The initial intention of this work was to provide a framework for expanding ENP scope of practice. Although not achieved at this stage, the discussions and experience to date have proved beneficial. The information obtained has provided an opportunity for stakeholders to acknowledge the complex



requirements necessary to progress the current restrictive model of ENP practice. The complexity of this stage of development is recognition that the move forward requires flexibility in the framework to ensure future changes can be met more readily. The future approach involves not only education and professional development issues for the ENP/C group at an individual level, but organisational issues around standardisation of the developing role, clinical governance issues, continuing acceptance, support and understanding from other multi-disciplinary groups within the organisation. Basing future work on these thoughtful insights and with further work it is hoped that a smooth and structured progression of ENP evolution of practice will ensue.

## CONCLUSION

At this large organisation, a team approach is being employed in order to address the scope of practice issues specific to ENP. These issues include identifying a framework to underpin the evolving clinical scope of practice in the absence of specifically developed ENP CPGs. This approach is necessary to ensure an ongoing workable ENP model is developed to address current and future patient needs. Preliminary discussions have led to open dialogue between ENP, medical and management teams and have provided important insights for the ongoing success of this undertaking. The discussions have highlighted the need to provide a service which meets patient demand in an environment of increasing pressure, ensuring multi-disciplinary team members collaborate in decision making, ultimately providing a satisfying, productive, and efficient clinical environment including fundamental issues of accountability and risk management.

The challenge involves developing and describing a framework which enables current practice to progress smoothly, making use of existing knowledge and experience; not only in the clinical sense but including issues of policy, role promotion, and role integration. In addition, the framework must incorporate systems that provide a safety net for ENP and patients, to ensure the highest possible standard of care is

maintained, and for the organisation to fulfil its obligations to patients and staff. Given the evolving nature of the ENP role in Victorian ED, this progression is seen as a challenge and a positive initiative in the battle to meet increasing service needs.

## RECOMMENDATIONS

It is recommended that further development of the ENP role - with particular reference to clinical practice - be tackled in a structured, multi-disciplinary manner with strong nursing representation.

It is further recommended that any future work have rigorous evaluation structures in place to provide evidence of outcomes of the proposed/implemented changes.

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# Challenges for midwives: pregnant women and illicit drug use

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## KEY WORDS

Illicit drugs, pregnant, midwives, antenatal care

## ABSTRACT

### Objective

The purpose of the paper is to introduce illicit drug use as a societal problem and describes the response of the Australian Government. Specifically the paper examines the use of illicit drugs by pregnant women and the role of midwives in supporting these women throughout pregnancy and birth.

### Setting

Maternity services, specifically antenatal care clinics.

### Conclusion

In Australia the rate of pregnant women who use illicit drugs is escalating. These pregnancies are high obstetric risk with potential for harm to both the mother and the baby. Pregnancy however is seen as 'window of opportunity'; a time to provide education, choices and support. The literature describes that for health professionals working with pregnant women who are illicit drug users is challenging and for some health professionals their interaction can be negative. Australia advocates harm minimisation and encourages harm reduction strategies. Midwives are in a position to implement these strategies within the maternity setting. Further research is recommended as well as professional development programs for midwives to upgrade knowledge and cultivate engagement skills to enable appropriate and positive interaction with pregnant women who use illicit drugs.

## INTRODUCTION

Illicit drug use is a major societal problem that puts increased demands on community, judicial and health services (Wright and Walker 2007; Burns et al 2006; Jos et al 2003). Midwives, health professionals and community members alike are challenged when confronted by illicit drug use and more so when the user is pregnant. Women who are pregnant and use illicit drugs are considered high risk and require sensitive responses that are appropriate to meet their needs (Wright and Walker 2007). Increased maternal and foetal morbidity is associated with illicit drug use (Abdel-Latif et al 2007). Service provision is complicated by the legal, social and environmental problems as well as a prevalence of negative attitudes of health professionals that provide the services (NSW Department of Health 2006; Armstrong 2005). Women who are pregnant and use illicit drugs sometimes find it difficult to access traditional referral services to maternity care. They often present late in pregnancy for antenatal care, or wait until in labour to access health services and are unlikely to disclose their drug use (Wright and Walker 2007; Bartu et al 2006; Scully et al 2004). This paper presents a brief overview of illicit drug use in Australia, the strategies adopted by the Australian government to manage illicit drug use, and profiles pregnant women who are illicit drug users. Also featured is the current challenging role of midwives working with pregnant women who are illicit drug users.

### How big is the problem in Australia?

The National Drug Strategy has produced a number of reports from a series of surveys, conducted in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2006 and 2009 (data not yet available). The survey questionnaires ask about drug related knowledge, awareness, attitudes, use and behaviours. Population sample comprises of persons 14 years and over. The results present a statistical profile of both illicit and licit drug use throughout Australia (Ministerial Council on Drug Strategy 2004). Burns (2006) suggests criminal prosecution or for pregnant women, the fear of losing custody of the child may distort the

measurements from these national studies. Accurate data on the prevalence of illicit drug use is limited. It has been suggested the stigma and consequences associated with using illicit drugs may prevent users from disclosing their addiction. Therefore, household random controlled surveys measuring population health behaviours are problematic and unreliable when it comes to illicit drug use (NSW Department of Health 2006). Illicit substance use in Australia significantly contributes to illness and disease, injury in the workplace, violence, crime and breakdown in families and relationships (Degenhardt et al 2009; Dowdell et al 2007; Burns et al 2006; Tuten et al 2004). Estimates of social and economic cost of licit and illicit drug use in 1998-1999 was \$34.5 billion dollars with substances such as tobacco and alcohol contributing more than 82% of the cost and illicit substances making up the remaining 17% (AIHW 2005).

The National Drug Strategy Household 2004 survey found that more than 2.5 million Australians aged between 15-64 years had used illicit drugs in the last 12 months, approximately 15.3% of the population (AIHW 2005). The survey results estimated there were 200,000 dependant users. The most common illicit drug used was cannabis (AIHW 2005) and more recently there has been a significant increase in the use of psychostimulants (methamphetamines, crystal methamphetamines and other related substances) (WHO 2004; Woudes et al 2004; Australian Bureau of Criminal Intelligence 1998; Hando et al 1997; ). 'Ecstasy' (the common name for the illegal synthetic drug called methylenedioxymethamphetamine [MDMA]) is in third position on the list as the most widely used illicit drug in Australia, with as many as 456,000 people admitting to having used this drug at least once and bingeing being a great concern (AIHW 2005). Heroin use has been decreasing since 1999, but significant death, injury and illness from this illicit drug is seen as the third common cause of death among 25-35 year olds (AIHW 2005). Inhalant and volatile substance use such as petrol, glue and some aerosols are found to be more prominent in Aboriginal and Torres Strait Islander communities

(AIHW 2005). Poly-drug use is the norm among illicit drug users and often involves a cocktail of alcohol, prescription and illicit drugs (AIHW 2005).

Australia's National Action Plan on Illicit Drugs 2001 to 2003-4 revealed several observations which included; a minority of the population use illicit drugs which represents a significant global burden of disease, death and crime (Degenhardt et al 2009). The report concluded that initiation to drug use occurred in the early teens and that more females are participating in illicit drug use which confirms the findings by Turner et al (2003). The number of pregnant drug users is nevertheless difficult to quantify (AIHW 2005). It is however assumed pregnant drug users are most often poly drug users combining both illicit and prescription drugs. In addition, where they live will have an influence on the drug of choice (NSW Department of Health 2006).

#### **Australia's drug 'problem' management strategy**

Managing illicit drug use has been a challenge for governments globally over the past 30 years (Ministerial Council on Drug Strategy 2009). Australia is party to a number of international treaties, working in collaboration with the United States of America (USA), Canada and the United Kingdom (UK) to combat drug production and trafficking of illicit drugs (Ministerial Council on Drug Strategy 2009). The Australian Government developed and implemented a national drug strategy in 1985, which includes a cooperative relationship between all states and territory governments and non government sectors. The main aim was to reduce supply, demand and harm (Ministerial Council on Drug Strategy 2004), with the primary focus for 2005-2010 on opioid use, specifically the prevention of premature death or infectious disease and provide treatment options (Ministerial Council on Drug Strategy 2009). For the future 2010-2015 there will be concentration on the significant rise in poly illicit and licit drug use (Ministerial Council on Drug Strategy 2004).

The basis of Australia's drug strategy since 1985 has been harm minimisation. Ritter and Cameron (2005) state firmly that contrary to some public opinion "Harm minimisation does not condone drug

use" (p 5). It aims to reduce drug related harm by improving the health, social and economic outcomes for the community and individuals with a wide range of approaches. There is certainly confusion over the use of terms whether it be harm minimisation or harm reduction, Ritter and Cameron (2005, p 6) define harm minimisation as a philosophical approach, and harm reduction as the specific interventions adopted to limit use. Ritter and Cameron (2005) maintain that harm reduction is failing the illicit drug using population as it may reduce harm but does not always reduce use. They conclude that a harm minimisation approach can be construed as contradictory with drug law reform that aims to reduce drug use, drug trafficking, and related crimes (Ritter and Cameron 2005).

Australia's drug policy highlights four main features; harm minimisation, comprehensiveness of the approach including education, partnerships between health, law enforcement and education agencies, as well as affected communities, business and industry and finally, all levels of governments work within this framework providing a balanced approach (Ritter and Cameron 2005). In a more positive light, Burrows (2005) asserts that in the Australian context, models that aim to reduce harm are working well. Allman et al (2007) maintain that harm minimisation strategies reduce health and social care service costs compared to the use of punitive measures.

Illicit drug use during pregnancy is a serious public health and welfare issue for the Australian Government that consumes valuable health care resources and contributes to infant mortality and morbidity (Abdel-Latif et al 2007; Fraser et al 2007; Bartu et al 2006). Pregnant women who also use illicit drugs typically have high support needs and present with a combination of risk factors (Moore 2003).

Australian and UK research suggests that interventions that address illicit drug issues alongside maternity services are useful in improving outcomes for mothers and their babies especially in reducing or stabilising illicit drug use (Dawkins et al 1997; Dowdell et al 2007). Programs that have shown effectiveness with pregnant and parenting mothers



who use illicit drugs are usually based on long term and intensive support for the whole family (Gruenert et al 2004).

### **The profile of the pregnant women who uses illicit drugs**

The number of pregnant women who use illicit drugs is not well known despite increased awareness that drug misuse and abuse has an impact on maternal and child wellbeing. Surveys undertaken in New South Wales (NSW), the Australian Capital Territory (ACT) and the National Household Drug Survey 2004 on populations aged 14 and over, suggest that up to 6% of all pregnancies, are affected by illicit drug use (Abdel-Latif et al 2007). Drugs of choice that pregnant women use included; heroin, cocaine, cannabis, and benzodiazepines (Turner et al 2003).

Scully et al (2004) found in their study that pregnant women who use illicit drugs are frequently poly drug users, with a high percentage using long term prescription drugs to treat anxiety and/or depression. It is understood that illicit drugs affect the growing foetus and also that licit drugs can be additive and cause harm to the developing baby (Hepburn 2004; Turner et al 2003). Carter (2002) maintains that in the USA an estimated 5.5% of pregnant women use illicit drugs during pregnancy. She asserts that 18% of American pregnant women consume alcohol during pregnancy and approximately 20.4% smoke cigarettes throughout pregnancy yet society is tolerant of licit drug use during pregnancy and intolerant of illicit drug use; even though both are iatrogenic to growing fetuses (Lyons 2002).

Pregnant women who are known to use illicit drugs are stigmatised and face severe consequences that can include incarceration and sometimes removal of children following birth. Carter (2002) maintains that these women are labelled as immoral and seen as deficient caregivers.

Pregnant women in the USA who also use illicit drugs, have limited access to available resources (Jos et al 2003). If these women present for antenatal care, they are required to participate in drug intervention programs. Jos et al (2003) claim that these women

are often single mothers with multiple children who have minimal or no financial support from the father(s) of the children.

Many women who use illicit drugs are socio-economically disadvantaged and may experience comorbidities of varying degrees (Adams 2008). These include gynaecological problems, mental illness, emotional or sexual abuse. In addition, they may live in poverty and/or be homeless. Such women generally have not completed school, are unemployed or lack employment skills, and have limited access to transport and childcare. Adams (2008) argues more than two thirds of the pregnant women who abuse illicit drugs are living in domestic violence.

Hepburn (2004), a UK based researcher found that women who use illicit drugs are repeatedly alienated from available financial resources, social support services and health care. She claims such women are unlikely to attend health care services until late in pregnancy because they may not realise they are pregnant, or they lack motivation and/or understanding about the benefits of antenatal care, and may be mistrustful of government agencies. This mistrust is related to a fear of legal ramifications, having unborn and or other child/ren removed, and display feelings of shame because they use illicit drugs (Adams 2008; Hepburn 2004; Jos et al 2003). DeVille and Kopelman (1998) believe women who are known to be users of illicit drugs experience public scrutiny during pregnancy; increased criticism of their capacity to protect their growing foetus and their capabilities to care for the baby once it is born are doubted.

Australian pregnant women who are illicit drug users have a similar profile to those reported in the international literature. Turner et al study (2003) found that illicit drug users were more likely to have depression and used a combination of both illicit and licit drugs. Bartu et al (2006) general description of the pregnant illicit drug user is socially disadvantaged, having chaotic lifestyles (Wouldes et al 2004) and accessing antenatal services late in an unplanned pregnancy. Nevertheless, there is limited information about the characteristics and health needs of the

Australian women who use illicit drugs in pregnancy (Burns et al 2006). In general terms, Burns et al (2006) large study found women to be younger than the general population having babies, smoked, presented late to antenatal services or in labour and more likely to have a premature baby requiring neonatal intensive care, which was exacerbated when women used opioids.

### **Neonatal outcomes**

Infants of mothers who use illicit drugs during pregnancy are significantly more likely have lower birth weight, head circumference and gestational age at birth with a preponderance for prematurity (Abdel-Latif et al 2007). Abdel-Latif et al (2007) found that maternal illicit drug use accounts for more than 6% of premature critically ill babies in neonatal intensive care unit in NSW and the ACT. In conjunction with these early problems the infant is then exposed to a number of potential risks. Evidence demonstrates that parents who use illicit drugs are linked with a raft of chronic life conditions (Dawe 2007). These may include parental psychopathology, socioeconomic disadvantage, social isolation and violence. Infants at potential risk are those whose mothers are young, have a low level of education and early age of onset of illicit drug use together with serious environmental risks, homelessness, lack of safety from violence, poor nutrition (Dawe 2007; Cousins 2005). Protective factors are required to be in place for the mother and infant in order for the infant and the subsequent child's resilience to grow (Resnick et al 1993). Thus pregnancy is an ideal window of opportunity for intervention (NSW Department of Health 2006). This opportunistic time offers to support women to make positive decisions about their own and their infant's wellbeing. Resnick et al (1993) suggests there is a significant protective factor against the risk of harm to the babies when mothers are emotionally and socially connected to their families.

### **Pregnancy 'a window of opportunity'?**

Research demonstrates that maternal child health outcomes are enhanced exponentially if women access antenatal care throughout pregnancy (Bartu

et al 2006). Antenatal care provides opportunity for service providers to offer health education, prevention and intervention designed to promote positive obstetric and paediatric outcomes. Pregnant women who use illicit drugs and who present for antenatal care are directed to services to minimise harm from drug use to themselves and the growing foetus. Although women who use illicit drugs and are pregnant often present late for health care, this is the time when they become visible to maternity services (Klee 1998). Studies from the USA (NSW Department of Health 2006) and UK (Klee et al 2002) and Australia (Burns et al 2006; Moore 2003) concur. Daley et al (1998) refer to this time not as a 'window of opportunity' but more a 'revolving door'. Illicit drug dependence is chronic with relapse seen as a real possibility (NSW Department of Health 2006). Dowdell et al (2007) supports the recommended 'National guidelines for management of drug use during pregnancy, birth and the early development years of the newborn' (Ministerial Council on Drug Strategy 2004) as a useful manual for both midwifery and other health professional practice when working with pregnant women who use illicit drugs. Midwives practice includes antenatal, intranatal and postnatal care. Practice is developed within professional, ethical and legal frameworks. Midwives are responsible for working within these boundaries and develop life skills appropriate for midwifery practice and the provision of women's centred care. Pelvin (2006, p. 223) identified some of the many 'life skills' required to work with women in partnership and collaborate with them and other professionals.

Klee et al (2002) suggests, midwives engagement with these women is the key to enable such change to occur. It is known that foetal toxicity can occur in the first trimester with outcomes of foetal abnormalities, whilst foetal growth and development is particularly important in the third trimester as well as the high risk of premature birth (Abdel-Latif et al 2007). Engaging with these women is crucial as they can be given vital information on the effects of illicit drugs on their baby's health as well as their own, be provided with specialised drug support in terms of

pharmacological regimes, and connect with services that will assist in their future parenting role (NSW Department of Health 2006).

One of the greatest fears for women who are pregnant and use illicit drugs is the possibility that their baby will be removed from their care (Burns et al 2006; NSW Department of Health 2006). The challenge for midwives and health professionals who work with these women is to make appropriate and sensitive notifications to protect the yet-to-be-born (Jos et al 2003).

### **Child Protection**

In Australia illicit drug use is a contributing and predicting factor in child abuse with more than 30% of the parents known to child protection, either as a recipient of care as a child themselves or through previous pregnancies (Cousins 2005). Protecting children is mandated by the Australian Government. In all jurisdictions of Australia "... some level of legislation requiring the compulsory reporting to state and territory child protection and support services of harm due to child abuse or neglect" exists (AIHW 2006). In Victoria, illicit drug use alone without other risk factors is insufficient for notification to child protection services.

There are challenges to the providers of maternity services, they are asked to comply with mandatory reporting requirements while trying to maintain a therapeutic relationship (NSW Department of Health 2006). It is felt by some providers that if the report is punitive or lacks feedback or communication from child protection on the outcomes of a case, there is an reluctance to notify the next time that abuse is suspected (Vulliamy and Sullivan 2000).

### **Health Professionals view**

A review of the literature revealed many health professionals hold stereotypical views and have negative attitudes towards women who use illicit drugs (Adams 2008; Wright and Walker 2007; Scully et al 2004; Grafham et al 2004; Jos et al 2003; Norman 2001; McLaughlin and Long, 1996; Corse et al 1995). These views, argue McLaughlin and Long (1996), hamper relationships between

health professionals and women but also impede the progress women make during the pregnancy and birth and the early postnatal period.

Norman (2001), Corse et al (1995) and McLaughlin and Long (1996) identified that nurses found it difficult and not satisfying to work with clients who use illicit drugs. Scully et al (2004) contend that negative perceptions increased when the illicit drug user was a woman and she was pregnant. Grafham et al (2004) agree, arguing that generalists prepared health professionals including nurses and midwives working with drug users found the work with this group stressful and believed that insufficient resources are made available to up skill them. Women who use illicit substances are viewed as 'tainted, blemished and polluted' (McLaughlin and Long 1996, p. 284). More importantly, and more damning, is the linked perception that illicit drug users are of weak personality; in some way corrupt and flawed (Norman 2001); fulfilling the idea that illicit drug users are prone to criminality, violence and manipulative. McLaughlin and Long (1996) found that the majority of nurses interviewed in a study in 1992 suggested that drug users constituted a threat to society; further perpetuating and reflecting the fear beliefs of society. Mental health nurses, drug and alcohol nurses, social workers were found to have a more positive attitude, greater knowledge and understanding of illicit drug users. Grafham et al (2004) study, highlighted the role of this group of professionals was seen by others as a 'soft option' and regarded at times negatively by other health professionals.

Health professionals are not immune to the societal norms and are influenced by their own backgrounds. Life-long attitudes and beliefs systems are difficult to change especially when they are seen as going against the tide of overwhelming and dominating practices, policies and beliefs in the community in which they live (Lyons 2002).

### **CONCLUSION**

Illicit drug use among pregnant women is increasing in Australia. Pregnancy is seen as high risk to both the mother and the infant but it is also an

opportunity to support women, adopt lifestyle changes to optimise positive health outcomes for themselves and their children. The literature supports engagement with women who use illicit drugs and advocates for a philosophy of harm minimisation and harm reduction strategies. There are opponents to harm minimisation and support for punishment and control. Commentators have rejected these latter strategies as harmful to the community as it alienates and stigmatises segments of the population and does not provide pathways towards recovery and acceptance. Evidence confirms that health professionals find it confronting to work with illicit drug users, particularly pregnant women and require special staff development skills to overcome these challenges. Midwives in particular are in an advantageous position to make a difference and support mothers who want to make changes. Further research is necessary to explore what it is like for midwives to work with women who use illicit drugs. Knowing more about these experiences will shed light on the complexities of this special relationship and inform contemporaneous midwifery practice.

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