

Nurse perceptions of models of health care provision in New Zealand

Research advisory paper

Introduction

In a rapidly evolving health environment facing significant challenges associated with an ageing population, ageing health workforce, increasing patient acuity, and resource constraint, there is widespread agreement that current models of health care provision will struggle to meet future health need. In 2011, NZNO developed a vision for nursing that outlined a future direction for nursing in a range of areas including health sector models of care (Clendon, 2011). With specific reference to models of care the vision states:

Innovative and flexible models of care that are person-centred will be developed and evaluated by nurses. Technology, enhanced communication, and new treatment modalities will be utilised to ensure that models of care are appropriate, cost effective and meet the needs of all people. People will be consulted about the models that best meet their needs and nurses will work collaboratively with other health professionals to meet these needs. The principles of whakawhanaungatanga, manaakitanga, rangatiratanga, and wairuatanga will continue to guide professional nursing practice...(p.12)

This project extends the vision by seeking nurse leaders' perceptions on models of care in order to ensure that development and implementation of models of care is based on best practice and the best available evidence as proposed in the vision statement and to ensure the nursing position is identified, articulated and relevant for policy development. A model of care describes the way in which services are designed and delivered and should:

- have a theoretical basis;
- be underpinned by evidence;
- incorporate defined standards and principles;
- include a framework that provides a structure for implementation and evaluation (Queensland Health, 2000; Davidson, Halcomb, Hickman, Phillips, & Graham, 2006).

Method

Utilising a broad qualitative approach, the study utilised a two step process of data collection. An initial narrative survey was sent to all NZNO College and Section chairs (20), members of the National Nursing Consortium (9), the Co-Presidents of NZNO, and NZNO Regional Council Chairs (11) for dissemination. This purposive sampling approach was used to target nurse leaders across New Zealand with the dissemination email requesting the survey be forwarded to other nurses who recipients thought may be interested in the survey. Nurse leaders were targeted due to the knowledge it was anticipated this group held in regard to models of care. It is unknown how widely the survey was disseminated beyond these groups but a total of 26 written narratives were submitted via the survey portal and a further 10 telephone interviews utilising the same set of questions were undertaken with those who either agreed to a request in the survey or who were identified during initial telephone conversations. The telephone interviews were not tape recorded but comprehensive notes were taken. In addition, a presentation and workshop were undertaken at NZNO Te Runanga's Annual General Hui (AGH) in August 2013. Participants were invited to consider the questions and place post-it notes on posters around the room with their thoughts on the questions. This data was collated into a single narrative. In

total, 37 narratives were analysed seeking common themes and patterns. NViVO qualitative data analysis software was utilised to aid analysis.

Ethics approval to undertake the study was obtained from Victoria University of Wellington's Human Ethics Committee: approval #20092.

Results

Demographics

The majority of survey and telephone interview participants were aged over 50 with this likely to reflect the purposive sampling approach that sought nurse leaders. Most were female (n=32/36), and of European ethnicity. There were 6 Māori participants. Participants came from a range of practice backgrounds including acute care settings (n=13), primary health care (n=10), management (n=5), professional advice (n=3), mental health (n=1), education (n=2) and 2 of unknown background. Participants at the NZNO Te Rūnanga AGH were all Māori and numbered approximately 115. Participants at the hui also came from a range of backgrounds including primary health care (n=31), mental health (n=7), DHBs (n=23), aged care (n=7) and other (mostly students, n=47).

Core themes

Analysis of the narratives identified five core themes and 15 associated sub themes. These are outlined in table one.

Table 1. Themes and subthemes

Theme	Descriptor	Sub themes
People as recipients of care	In this theme, the focus is on people as recipients of care	Patient-centred care Quality
Health professionals	In this theme, the focus is on health professionals and their scopes and roles in the provision of care	Interdisciplinary practice Nursing Leadership and authority Education
Communication	In this theme, the focus is on the value of communication in relation to quality of care	Interpersonal communication Integrated care IT infrastructure
Health delivery	Here, broad approaches to health care are described including barriers and facilitators to quality care	Primary health care The business model Cultural competence
Matauranga Māori	This theme focuses on approaches to health that are based around Māori ways of knowing.	Traditional practices Whānau-centred care Tuakana teina

People as recipients of care

(Patient-centred care, quality)

The premise that people should be at the heart of health care provision was strongly identified by participants in this study. Participants believed that people's opinions must be heard and respected, needs must be identified, and services and funding must wrap around the client. In addition, services must be of high quality, easily accessible and evidence-based.

People are central – work around their needs before health in NZ can be achieved – people must be central to health targets. (Participant – Te Rūnanga NZNO Annual General Hui)

A model of care that ensures that health care for the New Zealand people is accessible and of a high standard is important and imperative...(Clinical nurse specialist)

Patient-centred care is widely understood to contribute to improved patient-reported outcomes, improved communication, greater satisfaction with care, and improved biomedical outcomes (Cooper et al., 2012; Jayadevappa & Chhatre, 2011; Wilson, 2008). Yet despite these attributed benefits, definition of the term varies and barriers to implementation exist. Teekman (2012) argues that despite a desire to undertake comprehensive health assessment and provide patient-centred care, the introduction of generic management principles and continuous restructuring have reduced nurses autonomy to practice in this way. It will be important for nurses to consider ways in which these types of barriers can be overcome if patient-centred, quality care is to become a reality within future models of care.

Health professionals

(Interdisciplinary practice, nursing, leadership and authority, education)

Participants strongly identified interdisciplinary practice as a core element of future models of care.

Relationships and collaborative practice – there has to be a level of communication and respect between practitioners...(Primary health care nurse)

Barriers need to be broken down between nurses and doctors although I do feel in rural areas this has already happened due to necessity. Specialists in tertiary hospitals need to respect and value the nurses ability who are working in rural areas. This can be achieved by meeting and working with the teams in their environments so they get a good picture of the environment they are working in. (Charge nurse manager)

Interdisciplinary practice has been identified as one of the most effective approaches to chronic condition management (Boult et al., 2009), and as a contributor to improvements in patient care, decreased length of hospital stay and decreased costs of hospital stay (Zwarenstein, Goldman & Reeves, 2009). However, participants noted a need for greater clarity between HCA, CNS and RN roles with RNs needing to move their focus from 'caring for' to 'caring about' patients.

RNs are confused – they still think they are 'caring for' but need to switch to 'caring about'. They should have the primary relationship with the patient and demand accountability from the EN and HCA. RNs believe they are not as important as CNS, but need to do more than ENs and HCAs, and can't articulate this difference. The RN needs to think about who the patient is, what the whole package of care is for that person and the best way to give that care. (Educator)

Participants also expressed a strong belief in nursing and nurse-led care as a core element in future models of care. Types of nurse-led care mentioned by participants included: having a greater role in clinics and small, rural emergency departments; nurse-led clinics in long term conditions management, schools, and communities; nurse prescribing; patient management in specialty areas; higher numbers of nurses at the bedside managing the patient pathway; more and better use of NPs; nurses as business partners and owners in primary health care; and nurse-led discharge with community follow up and care. There is now substantial evidence to support the safety and efficacy of nurse-led care in both primary and secondary health care settings (see for example: Boult, et al., 2009; Glynn, et al., 2010; Griffiths, et al., 2007; King, Boyd, Carver, & Dagley, 2011; Kuethe, et al., 2013; Laurant et al 2004/2009; Parker, et al., 2012; Peri, Boyd, Foster, & Stillwell, 2013; Schadewalt & Schultz, 2010; Wilkinson, Carryer, Adams & Chaning-Pearce, 2011). However, participants in this study were concerned that frequently, roll out of models of excellence in nurse-led care was hindered by a lack of leadership at nursing and managerial levels.

Strong nurse leaders with authority in the practice setting were identified as required to ensure roll out of effective models of nurse-led care, have input into the wider development of models, and at the policy and strategic levels. Concern was expressed by participants that nurses were still struggling to have a voice at the decision-making table in some areas and that change was more likely where nurses were respected for their clinical expertise and given the time to review, reflect and research effective models.

...with advanced nursing practice – this still relies on individual leaders within nursing to drive change and not the evidence... (Nurse adviser)

Effective nursing leadership has been found to contribute to: improved patient outcomes, significantly reduced patient adverse events and complications; increased patient satisfaction, improved nurse productivity, and a positive working environment (Germain & Cummings, 2010; Wong & Cummings, 2007; Tomey, 2009). Nurses clearly require improved access to leadership programmes including recognition by funders of leadership and management education pathways.

Participants believed there were a number of changes that needed to occur in nursing education to ensure effective implementation of future models of care. Key points included the need to refocus education on teaching nurses how to manage the whole patient journey with a strong focus on delegation and direction of care, reworking the MN degree to include rotational clinical experience during practical courses, improving knowledge and understanding of business models and nurses role within these models, and improving student understanding of the way in which policy, strategy and funding intertwine to impact on health service delivery.

I suspect the BN needs major overhaul to increase focus on PHC strongly and to clarify that what RNs need to do in hospitals is plan, assess and evaluate care through skilled supervision and delegation of so called basic care. Understand the importance of RNs talking to/assessing patients and of participating in ward rounds and multi disciplinary meetings. At the moment they are meant to do everything and failing at all of it. Hence their misery. (Educator)

Communication

(Interpersonal communication, integrated care, IT infrastructure)

Effective communication between health professionals, with patients and across services was seen by participants as crucial to developing and implementing future models of care. Integrated care was identified by participants as essential for improving health outcomes in New Zealand, yet participants identified that there was still significant work to be done to achieve this particularly in relation to the need for appropriate funding, support, care pathways and information technology infrastructure.

Communication between primary, secondary and tertiary care needs to be much better – if notes would all link, people don't miss out. (Clinical nurse educator)

Effective communication is essential for achieving interdisciplinary practice, integrated care, and improved health outcomes (Sargeant, MacLeod & Murray, 2011). Formal training through interprofessional education can improve the communication skills of health practitioners and outcomes for patients and should be considered an appropriate intervention for improving communication skills (Reeves et al., 2013; Sargeant et al., 2011). Integrated care models show improved outcomes for people with chronic disease (Kruis et al., 2013), however other studies suggest that integrated care underperforms without sufficient engagement from health professionals, substantial start up funding, and appropriate service configuration (Calciolari & Ilinca, 2011; Coupe, 2013; Cummings, 2011; Smith, Allwright & O'Dowd, 2007). Clearly the issues identified by participants in this study are recognised as issues elsewhere and further work must be done to address these.

Health delivery

(Primary health care, the business model, cultural competence)

While participants had a range of suggestions for how models of care should be developed, primary health care and the business model were primarily identified as two broad approaches to health care systems that warranted comment. Primary health care encapsulated participants' ideas around the importance of addressing the social determinants of health if health gain is to be achieved, health promotion, self-management, preventative care and health literacy. Participants believed that a primary health care approach to health care should not be limited to community settings but was an approach that could and should be used in all settings to support patients and their families to lead healthy lives.

Better primary care, prevention of hospital admissions, wellness and health promotion programmes from birth through to death. A focus on health rather than illness. Efficient and timely referrals made to appropriate clinicians, using the skills and knowledge of all health professionals. (Care co-ordinator)

This approach is supported strongly in the literature (CSDH, 2008; National Expert Commission, 2012; WHO, 2008) and it is clear that the participants in this study recognise this role and wish to see funding and models prioritised to support primary health care approaches.

The business model sub theme captured participants' thoughts on business ownership, targets, productivity and fiscal prudence. While participants were strongly supportive of improving education for nurses around the business model including business skills and understanding of business processes, others felt the business model limited nurses' ability to practise effectively with clients. Conflict also exists in the literature regarding business approaches to health. For example, offering incentives in primary health care has limited efficacy in improving health outcomes (Scott et al., 2011) and yet the productive ward approach has been shown to have a positive impact in terms of patient and staff experience, increased direct care time, cost savings, and improved patient safety (Wright & McSherry, 2013; Schaefer, 2010). The greatest risk of a business approach is a failure to place the patient at the centre of health care. Evidence from the Mid Staffordshire Inquiry (Francis, 2013) and locally (Matheson, 2012) suggests there is a fine balance between the business model and improved patient outcomes. Where the balance is incorrect, patients will suffer. Regardless of the perspective, the business model is the predominant model in health at the present time and this is likely to continue. Despite misgivings regarding this approach, as participants noted, nurses need the skills to work and thrive in this environment.

For a number of participants there was a strong belief that New Zealand is in an ideal position to develop models of care founded on cultural competence, biculturalism and commitment to Tiriti o Waitangi. Participants believed this approach would benefit both Māori and non-Māori alike and should be embedded in health care delivery systems.

...we need to have a model that is inclusive of a bicultural focus, and one that focuses on cultural competencies being essential for high quality health care delivery and services. (Participant – Te Rūnanga NZNO Annual General Hui)

A model of care that embraces all cultures that are prominent in New Zealand and reflects the health needs of all... (Care coordinator)

Culturally competent health systems acknowledge diversity, provide culturally appropriate care, enable self-determination and reciprocity, hold governments and health planners accountable for meeting the needs of all cultures, base care on a culturally competent evidence-base and recognise the need for cultural competence training (McMurray & Clendon, in press). Culturally competent care is about the health practitioner or organisation's capacity to improve health status by integrating culture into the clinical context (Durie, 2001). In order for an organisation to achieve cultural competence in New Zealand, there needs to be an acknowledgement that most

people receive care from mainstream providers and have a right to receive culturally safe care in this environment. There must also be a commitment to biculturalism and implementing the Tiriti o Waitangi.

Matauranga Māori (Māori knowledge)

(Traditional practices, Whānau-centred care, Tuakana teina)

Participants who identified as Māori – including those who were interviewed, filled in surveys, or participated in the workshop held at the Te Rūnanga NZNO AGH – spoke of the importance of Māori-centred approaches to health care and the role of Māori nurses throughout the health sector. Along with the themes previously outlined, participants also wanted to see the inclusion of Māori cultural practices incorporated into models of care for Māori. These included traditional based practices and learning, more Marae-based facilities and initiatives, more Kaumātua input, whānau-centred care and whānau ora, greater leadership from Māori, Māori models of preceptorship, mentorship and professional development (tuakana teina, Ngā Manukura o Āpōpō), and being an active and equal partner in developing, designing and leading models of care for both Māori and non-Māori.

Speak up speak out, Mana, Tika, pono Aroha, Wairua, Tu Kaha - remain united and continue to speak your mind – leadership (Participant – Te Rūnanga NZNO Annual General Hui)

By Māori, for Māori health services along with mainstreamed kaupapa Māori health services are strongly supported in the literature as a means of addressing disparities in Māori health status. Such Māori-focused health services recognise and implement a Māori-centered approach to health care (kaupapa Māori services), and have been demonstrated as effective in reaching Māori whānau (Hamerton, et al., 2012; Ministry of Health, 2006; Oda & Rameka, 2012). Kaupapa Māori health providers not only improve access to affordable and accessible health care for Māori, they also contribute to the economic wellbeing of Māori communities and the Māori workforce (Ministry of Health, 2009).

Limitations

There are a number of limitations to this study that need to be recognised. Firstly, focusing on nurse leaders limited the potential pool of respondents and consequently there may be some bias in the findings. However, the findings presented here do not seek to represent the views of all nurses, simply those who took part in the study. It is hoped that the findings provide direction for policy makers and planners in terms of nurses' expectations and beliefs regarding models of care in New Zealand.

Conclusion and recommendations

Models of care is an extensive topic. This study has sought to understand nurse leaders' perspectives on models of care to ensure the nursing position on models of care is identified, articulated and relevant for policy development. The findings suggest that nurses have an in-depth knowledge of the way in which models of care can and should be developed in this country along with some of the barriers to development and implementation.

In summary, models of care in New Zealand should focus on the following key elements:

- > maintaining the person at the centre of health care;
- > ensuring the provision of quality, evidence-based health care;
- > providing mechanisms for enabling interdisciplinary practice;
- > clarifying roles and responsibilities between health professionals;

- > enabling the provision of nurse-led care;
- > facilitating nurse leadership and authority across the sector;
- > ensuring health professionals have appropriate education and skills to sustain change;
- > developing effective communication strategies throughout the sector;
- > focusing on primary health care as an overriding approach to health improvement;
- > maintaining a healthy awareness of the risks associated with the business model;
- > facilitating cultural competence, biculturalism and a commitment to Tiriti o Waitangi;
- > enabling Māori-centred approaches to models of care.

We recommend greater involvement of nurse leaders in model of care development across the health sector. We also recommend further New Zealand specific research into many of the aspects listed above. Nurses have a clear vision for how approaches to health care provision can be improved and it behoves funders, providers, and policy makers to ensure this perspective is acknowledged and included.

A full list of references and glossary of terms can be found in the main document: 'Nurse perceptions' of models of care provision in New Zealand' available on the NZNO website www.nzno.org.nz/resources/nzno_publications.

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Mission statement

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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