

Development and implementation of a nurse-led walk-in centre: evidence lost in translation?

Jane Desborough, Rhian Parker and Laura Forrest

J Health Serv Res Policy 2013 18: 174

DOI: 10.1177/1355819613488574

The online version of this article can be found at:

<http://hsr.sagepub.com/content/18/3/174>

Published by:



<http://www.sagepublications.com>

On behalf of:

NHS Confederation (HSRN)

Health Services Research Association of Australia & New Zealand (HSRAANZ)

Additional services and information for *Journal of Health Services Research & Policy* can be found at:

Email Alerts: <http://hsr.sagepub.com/cgi/alerts>

Subscriptions: <http://hsr.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

>> [Version of Record](#) - Jul 17, 2013

[What is This?](#)



Development and implementation of a nurse-led walk-in centre: evidence lost in translation?

Jane Desborough¹, Rhian Parker² and Laura Forrest³

Abstract

Objectives: The design of the first Australian public nurse-led primary care walk-in centre was modelled on those established in the English National Health Service (NHS). An independent evaluation of the first 12 months of operation of the Australian Capital Territory (ACT) Health walk-in centre, in 2011, analysed the translation of evidence from the national evaluation of the NHS walk-in centres to the policy development and implementation of the ACT walk-in centre. Whilst in a number of ways the evidence was used well, our interest for this paper was to examine three areas identified as problematic and to identify the points at which the evidence was lost or diluted.

Methods: In addition to data obtained through nurse and key stakeholder interviews for the evaluation, an analysis was undertaken of documents on the planning and establishment of the ACT walk-in centre, either provided to the evaluation team or made publicly available.

Results: Three areas were identified as problematic in the way that evidence from the NHS evaluation was translated: the use of clinical decision support software (CDSS); the marketing of the walk-in centre; and its location.

Conclusions: Our examination indicates that despite seeking evidence to inform the development of the ACT walk-in centre, the evidence was not fully used and some clear lessons ignored, resulting in much of the evidence being lost in translation.

Keywords

clinical decision support software, evidence-based medicine, health policy, knowledge translation, nurse-led, nursing, walk-in centre

Background

Like many countries, Australia is faced with providing comprehensive and timely primary health care services to an ageing population with high levels of chronic disease. Challenges are also being experienced in the supply of health professionals across the country. Despite the fact that Canberra in the Australian Capital Territory (ACT) is the nation's capital, shortages of health professionals, particularly general practitioners (GPs), are being experienced. Recent figures show that the ACT has 67.2 GPs per 100,000 people compared to the current national average of 90.7.¹ Amongst a range of strategies aimed to address this shortage and improve access to primary health care is a nurse-led primary care walk-in centre.

The key features of walk-in centres are as follows: they are nurse-led; have walk-in access, with no need for an appointment; have wide opening hours (in the ACT 7 am–11 pm daily); are in a convenient location;

generally treat minor illnesses and injuries and offer health promotion; provide nurse-led care supported by clinical decision support software (CDSS); aim to complement rather than replace existing health services; and (in England) have strong links with local GPs.²

The first Australian public nurse-led primary care walk-in centre opened in the ACT in May 2010. The aim of this centre was to fulfil an unmet primary health

¹Research Fellow, Australian Primary Health Care Research Institute, Australian National University, Acton, Australia

²Senior Research Fellow, Australian Primary Health Care Research Institute, Australian National University, Acton, Australia

³Research Fellow, Australian Primary Health Care Research Institute, Australian National University, Acton, Australia

Corresponding author:

Jane Desborough, Australian Primary Health Care Research Institute, Australian National University, Level 1, Ian Potter House, Gordon St, Acton, ACT 0200, Australia.
Email: jane.desborough@anu.edu.au

care need in the community demonstrated by the shortage of GPs, better meet projected demand for health care services and relieve pressure on the public hospital system.³ This ACT walk-in centre was modelled on walk-in centres established in the English National Health Service (NHS). The extensive body of literature arising from the evaluation of English NHS walk-in centres was reviewed to inform its design.³⁻⁶ To supplement this, a team from the ACT Health Directorate visited England 'to observe the structure and operations' of a number of established NHS walk-in centres.^{2:9} The availability of such evidence provided a valuable opportunity to learn from past experiences and through this, to refine and improve the model. To maximize this opportunity, the evidence needed to be well understood and translated into health policy and practice, keeping in mind local requirements and differences associated with the Australian health system.

There are a range of models for translating knowledge into policy and practice. These models have been described as the 'push' model, the 'pull' model and the 'interaction' model.⁷ These models describe the way that research findings are 'pushed' into policy and practice, the 'pulling' in of research to inform policy and practice and the interaction between researchers, policy makers and practitioners to address a lack of evidence in an area. In the context of the ACT walk-in centre, the 'pull' model was used.

Whilst the ACT Health Directorate actively sought evidence to inform the development of its service, the way this evidence was interpreted and applied did not always reflect the lessons from England. The aim of this paper is to analyse the translation of evidence from the evaluation of the NHS walk-in centres to the development and implementation of the ACT walk-in centre.

Methods

An analysis was undertaken of documents on the planning and establishment of the ACT walk-in centre, either provided to the evaluation team or made publicly available.^{2,8-11} As part of the broader evaluation, nurses who worked at the centre ($n = 13$) and key stakeholders ($n = 15$) were interviewed. Data from these interviews were also used for this analysis. All interviews were recorded and transcribed, and any identifying information about the participants removed. NVivo 8 software (QSR International Pty Ltd., Melbourne, Australia) was used to manage the data and facilitate coding. An initial deductive approach was applied to interview transcripts using content analysis structured according to themes identified during study design. An inductive approach was then used to identify new ideas,

concepts and patterns within the data, comparing for similarities, relationships and tensions.¹²

Ethical approval for this research was received from The ACT Health Human Research Ethics Committee and by The Australian National University Human Research Ethics Committee.

Results

We identified three problematic areas in relation to the translation of evidence from the NHS to the ACT: the use of CDSS; the marketing of the centre; and its location.

Use of CDSS

Evidence regarding the use of CDSS to guide nursing consultations at NHS walk-in centres highlighted difficulties encountered by the nurses related to this software. This evidence indicated that the adaptation of clinical support software originally developed for telephone consultations for use in face-to-face consultations was problematic³ and recommended caution when implementing CDSS. However, ACT Health chose to use a CDSS that was adapted from a program originally developed for telephone consultations.

The nurses acknowledged some benefits associated with using the CDSS. However, it was a source of frustration in terms of the time needed to develop and change protocols, and the time it took for these changes to be approved by the Walk-in Centre Clinical Advisory Group.¹³ Similar to the experience of nurses in the NHS,⁴ their capacity to deliver high-quality, timely nursing care was perceived to be hampered by the onerous and limiting nature of the CDSS.¹³

Respondent: It increases my consult times by 40 to 50 percent because of trying to navigate through the software and because I'm trying to find ways to navigate through the grey areas so the patient can get the best possible care... We're forced to go through every aspect of the patient's life before I will initiate something as simple as a hangnail [laughs] you know...

Nurses in the NHS experienced tensions between the extent to which they should rely on the CDSS or use their professional autonomy,³ whereas the nurses in the ACT Walk-in centre were not given the option to utilize professional autonomy due to a directive requiring them to use the CDSS at all times. This was a significant source of dissatisfaction for these highly trained nurses, which they believed limited their practice.¹³

Respondent: The computer system. It's lengthy, very, very lengthy. I could honestly see, a lot of these... don't

get me wrong I don't want to rush people through, but a lot of these simple cough/colds or these simple splinter removals or some of these very simple stuff that we're set up for that take us ten minutes to do, write a quick note and we're done, take us 20 minutes to half an hour because of the computer system.

On a practical level, the ACT Walk-in Centre CDSS was a standalone system, which could not interface with other systems within the ACT Health Directorate or the tertiary hospital campus, thus duplicate registrations and manual faxing of reports were required.¹³

Location of the walk-in centre

The ACT walk-in centre was located on the campus of Canberra's tertiary public hospital, approximately 100 m from the Emergency Department (ED). A key rationale for establishing the walk-in centre was to relieve pressure on the two existing EDs in the ACT.² This rationale, and a consultative process entered into by ACT Health involving local stakeholder groups, determined the location of the walk-in centre.^{9,10} The ACT Division of General Practice (ACTDGP) would not 'support stand alone nurse-led or allied health service centres that propose to substitute for services currently delivered by GP coordinated teams'^{9:4}; however, the Division agreed to trial the centre co-located at a hospital.

There were eight walk-in centres co-located with EDs in the NHS, which were included in the national evaluation. However, there were two distinct differences between the co-located walk-in centres in England and the ACT. First, in the NHS, patients were triaged on arrival to attend either the ED or the walk-in centre according to their needs. Whereas, in the ACT, the patients decided whether to present at the walk-in centre or the ED. Second, the co-located walk-in centres in the NHS were not nurse-led. Doctors and nurses moved between the walk-in centres and EDs in accordance with demand; in fact, 39.5% of patients in the co-located walk-in centres in the NHS were seen by a doctor.⁵

In England, patients who fell outside the scope of practice of nurses at the co-located walk-in centres could be seen and treated by a doctor, minimizing the need for referral to another service. In contrast, in the ACT, patients who fell outside the scope of practice of the walk-in centre were referred to other services, including the ED. Stakeholders noted that the location of the walk-in centre brought patients with primary health care complaints to a tertiary health care campus; if their complaint fell outside the scope of the walk-in centre, the patient often ended up in the ED inappropriately¹³:

Stakeholder: It would be better placed away from a tertiary care site – a shopping centre... This would prevent people who are presenting with primary care problems from subsequently presenting to tertiary care sector, ED if they can't be treated at the 'Walk-in Centre'.

There was no evidence from the national evaluation of the NHS walk-in centres that co-located walk-in centres had had 'any effect on attendance rates, process, costs or outcome of care' on the EDs.^{5:265} This lack of evidence had significant implications for the establishment of a walk-in centre on the campus of a tertiary hospital with the stated rationale of relieving pressure on the ED. Contrary to this rationale, the location of the ACT walk-in centre actually resulted in a 'net increase in ED activity'.¹³

Marketing

The highest users of NHS walk-in centres were those aged between 18 and 35 years.⁴ In England, this type of health service was found to be attractive to many in this age group, who enjoyed the anonymity afforded by a walk-in centre and for whom an ongoing relationship with a health care provider might not be considered important. However, improving access to health care for this cohort was considered problematic for a number of reasons including the increased cost of delivering health care services for minor health problems that might otherwise be self-managed at home.

With the idea that the co-location of the walk-in centre at the tertiary hospital would take pressure off the ED, the ACT policy makers targeted this cohort of 18–35 year olds, as at that time it represented '33% of the total number of ED presentations with minor conditions' and was a potential way to alleviate pressure on the EDs from this age group.¹¹ The peak age group of attendees was 20–29 years, with a mean of 29.6 and median of 27.^{13:32} Hence, the marketing campaign supported an increase in access to health care primarily for this mainly affluent and able group, reinforcing previous findings that 'walk-in centres represent another example of the inverse care law, whereby health care resources tend to be disproportionately spent on those groups at least risk, thereby increasing health inequalities'^{3:4} and, as previously stated, converse to its aims, the walk-in centre did not alleviate pressure from the ED through this campaign.

Discussion

The use of evidence to inform the development of the ACT walk-in centre provides an example of knowledge transfer in a 'user-pull' manner.¹⁴ The potential users of the evidence sought it to inform the planning of the

walk-in centre. However, in the three areas described, the way the evidence was interpreted or used had significant impact on implementation and subsequent outcomes, affecting those who chose to attend the walk-in centre, the care that was provided and the impact on the co-located ED.

Pawson et al.¹⁵ talk about ‘flows, blockages and points of contention’ when discussing the realities of using evidence to inform policy. ‘Intervention theories have a long journey. They begin in the heads of policy architects, pass into the hands of practitioners and managers, and (sometimes) into the hearts and minds of patients. Different groups and relationships will be crucial to implementation’.¹⁵ The success of an intervention thus depends on the cumulative success of the entire sequence of these mechanisms as the programme unfolds. Whilst a number of blockages or points of contention were observed at the policy level, difficulties with the CDSS were encountered at the implementation level affecting nurse consultations and hence provision of patient care.

There are a range of barriers to effective knowledge translation, including competing interests or values and ‘cognitive’, ‘structural’ and ‘organizational’, or ‘cultural’, constraints.¹⁶ Whilst nurse-led care has been found to be clinically effective in a variety of health care settings,¹⁷ the novel nature of nurse-led walk-in centres requires consideration of their integration into the existing health system;¹⁸ in this case, a system not experienced in nurse-led primary care and risk-averse.

The use of CDSS in primary care has been considered precarious, with evidence indicating that ‘patients’ reasons for consulting are multiple and complex and that a linear and mechanistic approach to their presenting complaints is unlikely to be appropriate’.³ Studies evaluating the ability of CDSS to improve clinical practice found that the majority of systems (66%) contribute to a positive improvement; however, for 34% this does not occur.¹⁹ Subsequent research identified a number of features which were ‘closely correlated with decision support systems’ ability to improve patient care significantly’.²⁰ With the NHS evidence advising caution in the use of CDSS in walk-in centres, consideration and application of further evidence might have resulted in a more effective application of CDSS at the ACT walk-in centre.

A key rationale for establishing the ACT walk-in centre was to reduce pressure on the ED, despite the English evidence of no impact. During the establishment of the centre, some interest groups were, and continue to be, vocal in their concern about the nurse-led model.^{9,21} These interest groups pushed for the centre to be established on a hospital site to ensure medical support was close by should the nurse-led model prove to be deficient in providing adequate patient care.²² The

ACT Division of General Practice’s caution regarding the walk-in centre was due to the absence of ‘medical supervision’^{9:5} and was also underpinned by knowledge that funds used in this way could mean a diminished possibility of enhancement of existing GP services.⁹ As Almeida and Bascolo^{23:S11} suggest ‘the formulation, implementation, and evaluation of social policies are heavily guided by the values and concepts of social realities shared by the leading actors in the various process levels, or by bureaucratic elites’. Had evidence from the NHS been heeded, the ACT walk-in centre would have been located in a more accessible community location.^{13:47}

Given that the walk-in centre was aimed at improving access to affordable and timely primary care, marketing could have been better directed towards marginalized groups, who would benefit from free access to primary care. Marketing the ACT centre to a younger group seemed responsive to two things: a misunderstanding of the English experience in regard to the impact of walk-in centres on co-located EDs and other health care providers; and a lack of regard for the fact that the NHS walk-in centres had increased demand from a cohort who were not underserved, rather than improving equity of access. The two pieces of evidence were inconsistent and resulted in poor knowledge translation.

Lavis^{24:37} notes that ‘Public policymakers must contend with a particular set of institutional arrangements that govern what can be done to address any given issue, pressure from a variety of interest groups about what they would like to see done to address any given issue, and a range of ideas (including research evidence) about how best to address any given issue’.

The application of knowledge and experience from another setting is not always straightforward, as context and ‘culture’ matters. There is often what has been coined the ‘precautionary principle’²⁵ which urges policy makers to be... ‘watchful and circumspect’.^{25:172} It may well be that the pressure of powerful interest groups, such as the medical profession,⁹ and a precautionary mindset led those closely involved in implementing the walk-in centre policy to take little heed of the evidence about the location of the centre and the use of the CDSS. However, the marketing of the centre to a specific demographic group seemed to be more a failure to target the population in most need of access to primary care.

Conclusions

The modelling of the ACT centre on the English NHS centres was sensible given that such a service had not previously been implemented in Australia. The availability of evidence from the evaluation of those centres

could have been a powerful tool to support the development and implementation of an appropriate model for Australian primary care. Despite seeking out evidence, this seems to have been used selectively and cautiously, at times misinterpreted, and largely influenced by the views of powerful interest groups. We conclude that this contributed to much of the evidence being lost in translation.

Declaration of conflicting interests

The Independent Evaluation of the Nurse-Led Walk-in Centre was funded by the ACT Health Directorate. The information and opinions expressed in this paper do not necessarily reflect the views or policy of the ACT Government. The Australian Primary Health Care Research Institute is supported by a grant from the Australian Government Department of Health and Ageing. The information and opinions contained in it do not necessarily reflect the views or policy of the Australian Government.

Funding

The authors acknowledge the financial support of the ACT Health Directorate who funded the evaluation of the ACT Nurse-led Walk-in Centre.

References

1. ACT Division of General Practice. *ACT Division of General Practice 12 month report 2009–2010*. Edited by Primary Health Care Research and Information Service (PHCRIS). ACT, Australia: ACT Division of General Practice, 2010.
2. ACT Health. *Walk-in Centres in the Australian Capital Territory*. Discussion Paper. Canberra: ACT Health, 2008.
3. Salisbury C. Do NHS walk-in centres in England provide a model of integrated care? *Int J Integr Care* 2003; 3: e18.
4. Salisbury C, Chalder M, Manku Scott T, et al. What is the role of Walk-in Centres in the NHS? *BMJ (Clin Res Ed)* 2002; 324: 399–402.
5. Salisbury C, Hollinghurst S, Montgomery A, et al. The impact of co-located NHS walk-in centres on emergency departments. *Emerg Med J* 2007; 24: 265–269.
6. Salisbury C, Manku-Cott T, Moore L, et al. Questionnaire survey of users of NHS walk-in centres: observational study. *Br J Gen Pract* 2002; 52: 554–560.
7. Landry R, Amara N and Laamary M. *Utilization of social science research knowledge in Canada*. Québec, Canada: Groupe de recherche sur les interventions Gouvernementales (GRIG) Département de science politique Université Laval Québec, 1998.
8. ACT Health. *Walk-in Centres: Operational Model of Care. Version 3*. Edited by Innovation Redesign and Access Improvement Program. Canberra: ACT Health, 2010.
9. ACT Division of General Practice. *Walk-in Centres in the ACT*. ACT, Australia: ACT Division of General Practice, 2009.
10. ACT Health. *Walk-in Centres Detailed Model of Care. Version 3.0 edition*. Edited by Innovation RaAIP. Canberra: ACT Health, 2009.
11. Ainsworth B and Hayward S. Developing an innovative model of care for nurse-led walk-in centres in the ACT. *Australian Nursing Journal* 2010; 18: 28–31.
12. Yardley L and Marks D. *Research Methods for Clinical and Health Psychology*. London: Sage, 2004.
13. Parker RM, Forrest LE, Desborough J, et al. *Independent Evaluation of the Nurse-Led ACT Health Walk-in Centre*. Canberra: Australian Primary Health Care Research Institute, 2011.
14. Mitchell P, Pirkis J, Hall J, et al. Partnerships for knowledge exchange in health services research, policy and practice. *J Health Serv Res Policy* 2009; 14: 104–111.
15. Pawson R, Greenhalgh T, Harvey G, et al. Realist review – a new method of systematic review designed for complex policy interventions. *J Health Serv Res Policy* 2005; 10(Suppl 1): 21–34.
16. Haines A, Kuruvilla S and Borchert M. Bridging the implementation gap between knowledge and action for health. *Bull World Health Org* 2004; 82: 724–733.
17. Laurant M, Reeves D, Hermens R, et al. Substitution of doctors by nurses in primary care. *Cochrane Database Syst Rev* 2005; 2: CD001271.
18. May CR, Mair FS, Dowrick CF, et al. Process evaluation for complex interventions in primary care: understanding trials using the normalization process model. *BMC Family Practice* 2007; 8: 42.
19. Hunt D, Haynes R, Hanna S, et al. Effects of computer-based clinical decision support systems on physician performance and patient outcomes: a systematic review. *JAMA* 1998; 280: 1339–1346.
20. Kawamoto K, Houlihan CA, Balas EA, et al. Improving clinical practice using clinical decision support systems: a systematic review of trials to identify features critical to success. *BMJ* 2005; 330: 765.
21. Nurse centres costly mistake: AMA. *The Canberra Times*, 2011.
22. Forrest L and Parker R. Recruiting new allies in battle to save health care. *The Canberra Times* 2009.
23. Almeida C and Bascolo E. Use of research results in policy decision-making, formulation, and implementation: a review of the literature. *Cad Saude Publica* 2006; 22: S7–S19. (2006).
24. Lavis JN. Research, public policymaking, and knowledge-translation processes: Canadian efforts to build bridges. *J Continuing Educ Health Professions* 2006; 26: 37–45.
25. Monaghan M, Pawson R and Wicker K. The precautionary principle and evidence-based policy. *Evidence & Policy: J Res Debate Practice* 2012; 8: 171–191.