CNJ_20_2_internal.qxd 26/11/2005 9:55 AM Page 180

Copyright © eContent Management Pty Ltd. *Contemporary Nurse* (2005) **20**: 180–192.

A collaborative model of community health nursing practice

ABSTRACT

This paper discusses a strategic collaborative partnership between a Western Australian university and a community health service based on a Practice–Research Model. The partnership has involved a senior academic (0.2 FTE) working in the community health setting as a Nurse Research Consultant since 1998. The first section of the paper draws on the nursing literature on collaborative models and describes the broad background to the partnership and development of the Model. The second section presents in detail the results of a recent evaluation that involved a brief survey and follow-up interviews to determine community health nurses' understanding and perceptions of the partnership Model. Three main themes emerged from the interviews: (1) Advancement of learning *captured the extent to which the Nurse Research Consultant position helped to educate nurses and promote and develop research and best-practice; (2)* Job satisfaction and self-confidence *encompassed the extent to which participants felt nursing management were supportive of their professional education and pursuit of best-practice solutions, and (3)* Situational opportunity*, which reflected the more negative comments expressed by participants and related mostly to the restricted availability of Nurse Research Consultant and a focus on mainstream research priorities. The results suggest that the partnership Model provided the nurses with the opportunity to develop an increased understanding of the role of research in clinical practice and confidence in their own ability to reflect on current nursing practice. This allowed them to identify clinical problems in order to deliver and evaluate best-practice solutions, as evidenced by a change in attitude from the previous evaluation. However, it was also noted that the operational performance of the Model needs continual monitoring to ensure that all nurses have equitable access opportunities.*

KEY WORDS

collaboration; Practice–Research Model; nurses' perceptions; community health nurses; nursing practice

Received 10 February 2004 *Accepted 2 November 2005*

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 181

JILL DOWNIE
Head, School of Nursing and Midwifery
Curtin University of Technology *and*
Research Consultant
South Metropolitan Population
Health Service
Perth, Western Australia

SUE OGILVIE
Principal Community Health Nurse
Population Health – South
Metropolitan Area Health Service
Kwinana, Western Australia

HELEN WICHMANN
Research Assistant
School of Nursing and Midwifery
Curtin University of Technology
Perth, Western Australia

INTRODUCTION

The nursing profession is faced with increasingly complex health care issues driven by technological and medical advancements, an ageing population, increased numbers of people living with chronic disease, and spiralling costs. Collaborative partnerships between educational institutions and service agencies have been viewed as one way to provide research which ensures an evolving health-care system with comprehensive and coordinated services that are evidence-based, cost-effective and improve health-care outcomes. These partnerships also ensure the continuing development of the professional expertise necessary to meet these challenges.

In recognition of the above challenges a Western Australian metropolitan university and a health service embarked on a collaborative partnership agreement that has involved the integration of a senior academic (0.2 FTE) into the community health service to work as a Nurse Research Consultant (NRC). The broad aim of this collaborative appointment has been to enhance nursing research activity and the implementation of evidence-based nursing practice within the community health service. This resulted in the development of a Practice–Research Model (PRM) of collaboration and ongoing research activity guided by the Model (Downie et al., 2001). The aim of this paper is to discuss the strategic collaboration and to describe the results of a recent evaluation that explored community health nurses' (CHNs) understanding and perceptions of the partnership, which is based on the PRM.

BACKGROUND

The nursing literature presents several collaborative models that have emerged between educational institutions and clinical agencies as a means to integrate education, practice and research initiatives (Boswell & Cannon, 2005; Campbell & Taylor, 2000; Dunn & Yates, 2000; McKenna & Roberts, 1998; Acorn, 1990), as well as, providing a vehicle by which the theory–clinical practice gap is bridged and best practice outcomes are achieved (Gerrish & Clayton, 2004; Gaskill et al., 2003; Wallin et al., 2003; Retsas, 2000; Hutelmyer & Donnelly, 1996; Donnelly, Warfel & Wolfe, 1994; Lathlean, 1992; Acorn, 1990, 1991; Kelly et al., 1990; McKenna & Roberts, 1998; Crane, 1989; Rusmussen, 1984).

As noted by Downie et al. (2001) the majority of these models are based on a joint appointment model where the nurse is initially employed by a health service or a university and divides his or her time between teaching and clinical practice. Beitz and Heinzer (2000) and

Dunn and Yates (2000) discussed in detail the various types of joint appointment models, which vary considerably in terms of the aims, responsibilities and outcomes. More recent collaborative practice initiatives are based on the development and evaluation of nursing research and best practice outcomes through research within the clinical setting (Gerrish & Clayton, 2004; Dufault, 2004; Gaskell et al., 2003; Wallin et al., 2003; LeGris et al., 2000).

In a broad sense, all the models pursue collaboration as a means of developing trust, recognising the equal value of stakeholders and bringing mutual benefit to both partners in order to promote high quality research, continued professional education and quality health care (Orb, 1999). The literature supports the utility of such collaborations. For example, the most frequently cited positive outcomes are job satisfaction, improved educational experiences for pre-registration nursing students, increased self-confidence and improved knowledge base for nurses. Less common in the literature is an appreciation and reporting of the difficulties associated with these models. However, insufficient time, role overload, role ambiguity, role conflict, burnout, lack of power, authority and support have been reported as the barriers to the development of nursing research skills to deliver and evaluate best-practice solutions (Gerrish & Clayton, 2004; Wallin et al., 2003; Crawford et al., 2002; Retsas, 2000).

It is apparent that a large proportion of the models cited in the literature actually describe interdisciplinary research projects, cooperative multi-site projects, or collaborative projects, rather than any strategic plan for ongoing collaboration (Boswell & Cannon, 2005; Gerrish & Clayton, 2004). Further, the models appear to be based on a 'top-down' approach where 'academics designed research projects that they perceived to be important, sometimes without consultation with those working at the "grass-roots" level in the clinical area' (Downie et al., 2001: 30). As Gaskell et al., also noted about this approach 'it could be questioned whether this is, in fact, collaborative research' (2003: 348).

Only a few of the models cited in the literature address the consequences of adopting this 'top-down' approach (Gaskill et al., 2003; Le Gris et al., 2000; Campbell and Taylor, 2000; Pillar and Solem, 1999). Fewer still appear to have been specifically designed to promote the tenet that 'practice drives research '. The Maternal Child Healthcare Bureau's (MCHB) pyramid model (Magyary & Brandt, 2005) is one exception with a conceptual framework for defining the private–public sector health-care partnerships necessary to achieve optimal health for children with special healthcare needs, and their families and communities. The Collaborative Research Utilization (CRU) model is another example. This model conceptualised reciprocal relationships among clinicians, scientists and students in acute care settings to identify clinical problems, critique the available research evidence, explore the clinical applicability of the evidence and integrate change to practice via research roundtables (Dufault, 2004). The practitioner-led Evidence-Based Council model also conceptualised a framework to facilitate the dissemination and integration of evidenced-based practice across an organisation, as well as to generate research questions from practice (Gerrish & Clayton, 2004).

Another model that has attempted to reverse the usual 'top-down' approach is the Practice–Research Model (PRM) (Downie et al., 2001). The collaborative partnership evaluated in this paper is based on the Model.

Practice–Research Model (PRM)

The PRM was designed by a metropolitan community health service and a Western Australian university to facilitate and operationalise the collaborative partnership agreement between the organisations. Details of this agreement and the core values and aims underpinning the implementation of the Model have been

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 183

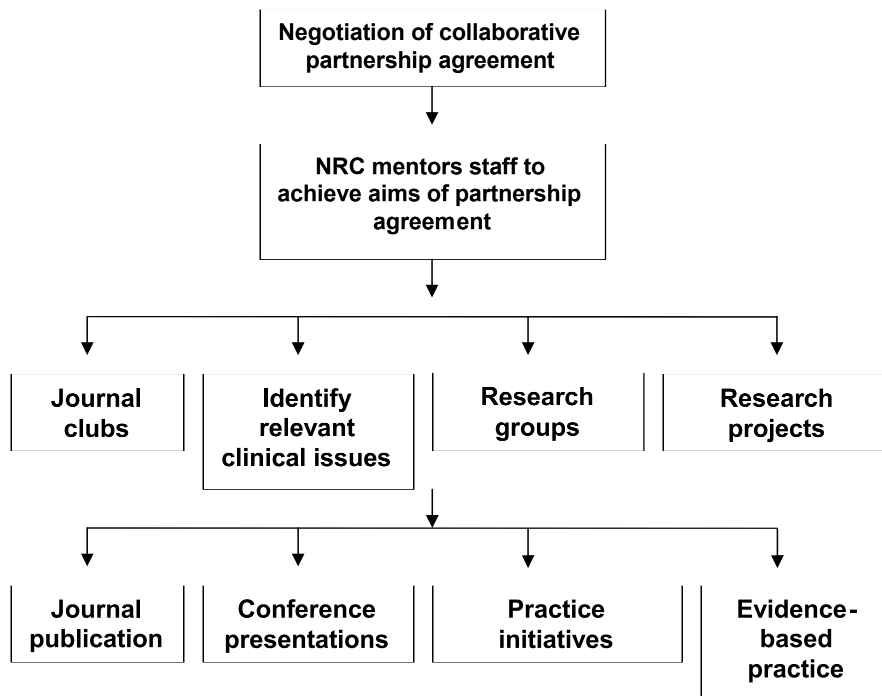

FIGURE 1: PRACTICE–RESEARCH MODEL OF COLLABORATION

described elsewhere (Downie et al., 2001). Figure 1 schematically represents the key elements underlying the process of collaboration and development of the PRM, which will be described briefly below.

Collaborative partnership

The collaborative partnership was formed by nursing health professionals, from the community health service and the university who recognised the need to bridge the theory–clinical practice gap and acknowledged the futility of continuing to work in isolation from each other. In practical terms, this involved a formal contractual arrangement between the organisations that led to the establishment of a Nurse Research Consultant (NRC) position. The academic in this position worked in the health service one day per week from 1998 to 2005 and the university is renumerated for their time. Another academic has since taken up the same role.

Core values and aims of the collaborative partnership

Before the actual framework of the collaborative partnership was decided, a literature review of the most common models of collaboration in nursing practice was used to promote discussion between the organisations to clarify and formalise the assumptions underlying the core values, roles and responsibilities of the partners, as indicated by Spross (1989). During this phase, four key concepts emerged: firstly, that 'practice drives research'; secondly, the principle of 'collegial partnership'; thirdly, 'collaborative ownership', and finally, 'best practice' (Downie et al., 2001).

As a consequence of this process of clarification and negotiation, the Practice–Research Model was developed to operationalise the agreed aims of the partnership, which were:

- To encourage nursing staff to reflect on current nursing practice in order to develop meaningful research proposals;

- To teach staff the research process via research experience;
- To enable nursing staff to have a key role in the professional development of other staff via the dissemination of research and quality improvement findings; and
- To plan and implement changes to practice based on research evidence.

Nurse Research Consultant (NRC)

In the PRM, the role of the Nurse Research Consultant (NRC) was articulated as that of mentor and consultant on issues related to research, methodology publications and dissemination. Although the PRM was specifically designed to enhance nursing research activity and the implementation of evidence-based community health nursing practice, the Model also encouraged the involvement of the multi-disciplinary team to work to achieve the aims of the partnership agreement.

Operational framework of the PRM

To fulfil the aims of the partnership several key elements formed the operational framework of the collaborative agreement. One important element of the framework was to enhance nursing staffs' knowledge of the research process via research experience. To achieve this 'Journal Clubs' were established in the community health service on a monthly basis. The NRC then worked with staff to identify, plan and implement changes to practice based on research evidence.

A second important element of the PRM was to encourage nursing staff to reflect on current nursing practice and identify clinical problems based on their knowledge and experience of nursing in order to develop meaningful research proposals and best-practice guidelines. For a full description of the research activities, training programs and outcomes completed under the PRM in this community health service refer to Downie et al. (2001). Similarly, a description of another collaborative partnership based on this Model can be found in Chapman and Combs (2005).

Perhaps of greater importance to the success of the collaborative arrangement has been the provision of infrastructure to support the dissemination of research and quality improvement findings through clinical meetings, workshops and conference presentations by the nursing staff involved in the various projects. Thus, the professional development of staff is a key element of the Practice–Research Model of collaboration, with client care the beneficiary of the process.

PRACTICE–RESEARCH MODEL EVALUATION

Design

Nursing management adopted a two-step approach to its most recent evaluation of the PRM that combined quantitative and qualitative methodology. Part one included a short evaluation survey and part two involved in-depth individual interviews with community health nursing staff.

Ethical approval

Approval to conduct the study was sought from and granted by the health service and the Ethics Reference Group for the community health service. Approval from the University's Human Ethics Committee was not required as clients and university personnel were not directly involved with the evaluation.

Sample

All nurses working in the community health service (e.g., child health, school health and district nurses) were invited to participate in the evaluation ($N = 37$).

Procedure

In Part one of the evaluation self-administered evaluation forms, along with an Information Sheet, were sent to all nurses in their workplace and they were asked to return them via the prepaid envelope supplied. The Information Sheet

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 185

outlined the purpose of the evaluation, the voluntary nature of participation and a statement ensuring confidentiality of individual responses. Consent to participate in the evaluation was implied by return of the evaluation form, which was completed anonymously.

In Part two, the sample available for in-depth interview included only those community health nurses who indicated in Part one their willingness to be contacted for a follow-up interview (*N* = 19). A purposive sample of six nurses was selected for interview on the basis of responses to the first part of the evaluation. To ensure a diversity of opinion three nurses were selected on the basis of a positive response set and three nurses on the basis of a 'more negative response set' to items Q11–13 on the evaluation form (refer Box 1).

Evaluation forms

In Part one, a short 13-item evaluation form (Box 1) was constructed and pilot-tested by the authors on a small convenience sample of nurses, not involved in the main study, to gain a demographic profile of the CHNs in the evaluation. In addition, the evaluation included items to ascertain nurses' perceptions of job satisfaction, their views regarding the impact of scholarly activities on their nursing/research knowledge base, and to elicit knowledge of quality improvement initiatives since the introduction of the collaborative partnership Model.

In the second part of the evaluation, a six-item interview schedule (Box 2) was developed by the authors to explore in detail the CHNs' understanding and perceptions of the Practice–Research Model of collaboration that exists between the university and the community health service.

Analysis

Analysis of data from the evaluation involved the use of the Statistical Package for the Social Sciences (SPSS). Descriptive statistics, including

Box 1: Items included on the evaluation form

1. What is your age in years?
2. Describe your highest level of education completed:
   - Hospital based only
   - Hospital based with a post-registration tertiary course
   - Tertiary degree
   - Post-graduate degree
   - Other
3. Other nursing courses completed, or qualifications attained.
4. How many years post-registration work experience have you had?
5. How many years experience have you had working in community nursing?
6. What is your current position in the community health service?
7. What is your current level in nursing?
8. What health service cluster do you belong?
9. Related to your work, please indicate the **positive aspects** of the collaborative nursing research model which currently operates between [name] university and the health service (e.g., journal clubs, research activities, nurse research consultant as a resource) …
10. Related to your work, please indicate the **negative aspects** of the collaborative nursing research model which currently operates …
11. Have you gained more knowledge about nursing practice over the past 12 months?
    - Yes
    - No

    Can you give an example?
12. Has your job satisfaction increased over the past 12 months?
    - Yes
    - No

    Please explain?
13. Has the collaborative research model contributed to your knowledge of quality improvement activities?

If you are comfortable being interviewed regarding this topic please indicate your interest by completing the form:

Name ………………………………………………

Contact telephone number ………………………

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 186

Box 2: Items included in the in-depth interview

1. Tell me about your perception of the collaborative arrangement that the health service has with the university, for the development of nursing research.
2. Can you describe your satisfaction with your employment? Has this changed in the past two years?
3. Describe the self-confidence in your nursing practice since the introduction of the Model.
4. Describe any changes to your nursing practice role with the introduction of the collaborative partnership in research.
5. Has the collaborative practice model contributed in any way to your nursing/research knowledge base over the past two years?
6. Discuss the scholarly activities you have engaged in over the past two years.

mean and frequency data, were used to describe participants' demographic, work experience and perceptions of the PRM. To analyse the qualitative data in Part Two the colour-coded content analysis procedure of Burnard (1991) was used to identify themes and common categories relevant to the evaluation. This process involved line-by-line coding to reduce the data into key words, phrases or concepts. The concepts were then colour-coded and clustered to identify patterns or relationships to enable more sophisticated interpretation. The analysis, however, remained at the descriptive level.

Results

Part One

Thirty-five community health nurses completed the Part one evaluation form, which constituted a response rate of 98%. The average age of nurse participants was 49 years (SD = 7.48 years; range: 35–61 years). More than half (54%) of the participants indicated they had completed tertiary qualifications in nursing, with 20% educated to post-graduate level. Eighty per cent of nurse participants indicated they had completed additional post-basic courses, or were involved in continuing education. Table 1 details the most common post-basic courses completed. Ninety-one per cent of the CHNs worked as Level 2 registered nurses, with the remaining nine per cent working at Level 3.

The experience of the CHNs was evidenced by the number of years they had worked post qualification, which ranged from nine to 40 years (M = 22.89 years, SD = 7.68 years). The number of years worked in community health was, however, approximately half of their total experience, ranging from six months to 28 years (M = 11.47 years, SD = 7.17 years). Approximately equal numbers of CHNs participated from the three work areas within the health service (i.e., Cockburn, n = 12; Melville, n = 10 and Fremantle, n = 12).

Analysis of the evaluation items on the Part one form revealed that the majority of CHNs were supportive of the collaborative partnership and the Model in use. Table 2 details participant responses to the items of interest on the evaluation form.

In particular, the majority of community health nurses (83%) acknowledged an increased knowledge base in relation to research, and gave examples of their own application of theory to practice. A substantial number of nurses (61%) also noted improvements in their knowledge of quality improvement initiatives and gave examples of how their documentation and practice has changed. Further, the responses encompassed by this item indicated that this was a highlight of the model. Generally, CHNs indicated that they were satisfied with their job during the previous 12 months (68%); however, since no base-line data was collected on this item it was not possible to causally relate current job satisfaction to the collaborative partnership model.

Less positive comments from participants regarding the collaborative partnership, as indi-

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 187

TABLE 1: THE MOST COMMON POST-BASIC COURSES COMPLETED BY CHNS (PERCENTAGE)

Post-basic course	%
Community & child health	60.0
Midwifery	60.0
Immunisation	40.0
First aid, accident and emergency	20.0
Remote area nursing	20.0
Counselling	20.0
Diabetes education	20.0
Nursing management	20.0

TABLE 2: NUMBER (%) OF COMMUNITY HEALTH NURSES WHO INDICATED CHANGE DUE TO THE MODEL

Evaluation item	Yes	No
Gained more knowledge	29 (82.9)	6 (17.1)
Job satisfaction*	23 (67.6)	11 (32.4)
Quality improvement initiatives*	19 (61.3)	12 (38.7)

* Total reflects missing data, percentage equals valid %.

cated by a 'more negative response set' to items Q10–13 on the evaluation form, were the result of nurses having little exposure to the Research Nurse Consultant because the community health service had not targeted their particular area as a research priority. Interestingly, more negative comments were more typical of older CHNs who were hospital trained.

Part Two

The community health nurses who participated in Part Two were younger than the sample as a whole (M = 45.20 years, SD = 8.04 years, range: 35–56 years), but had approximately the same amount of experience post qualification (M = 23.00, SD = 7.16 years, range: 11–30 years) and working in community health (M = 9.75 years, SD = 3.19 years, range: 4–12 years). Qualifications included 17% with a post-graduate degree, 33% with a tertiary degree and 50% with hospital training only. All participants who responded indicated that they were involved in extensive continuing education (ie., one non-response). Table 3 details the post-basic courses completed by participants in Part Two.

The majority of participants identified themselves as school health (33%), child health (33%), or generalist nurses (17%). One participant worked in staff development (17%). Approximately equal numbers of CHNs participated from the three work areas within the health service (eg., Cockburn, Melville and Fremantle). In general, the three community health nurses selected for interview on the basis of a positive response set were younger and had less post-initial and community health work experience than the three CHNs who had been selected on the basis of a 'more negative response set'. The former group (i.e., positive responders) were also less likely to have completed hospital training only (positive: 33% vs negative: 67%).

TABLE 3: PERCENTAGE OF CHN INTERVIEWEES WHO COMPLETED POST-BASIC COURSES

Post-basic course	%
Community & child health	64.3
Midwifery	64.3
First aid, accident and emergency	25.0
Immunisation	21.4
Lactation adviser's program	10.7
Counselling	10.7
Diabetes education	10.7
Nursing management	7.1

The results for Part Two were based upon analysis of six in-depth interviews. Ten key categories were identified in the qualitative data which were initially collapsed into four main concepts. These were identified as (1) the advancement of learning, (2) job satisfaction, (3) self-confidence and (4) situational opportunity. The job satisfaction and self-confidence concepts were subsequently combined because it appeared the terms were being used interchangeably. The resulting three themes will be discussed below.

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 188

Advancement of learning

Participants considered that one of the major highlights of the collaborative partnership and the Model was the extent to which their ability to understand and critique the research literature, their ability to identify clinical problems and develop best-practice solutions was enhanced.

This theme encompassed the importance of the NRC as the facilitator of learning, which was expressed in terms of the encouragement given. The NRC was seen by participants to be patient, approachable and someone who listened carefully to their viewpoints:

> I see it very much as a two way process between us and her, she's very approachable, she listens intently when we have an opinion so it's not all one sided, it's not all her research and I also can find that it's a two way process …

Another important function captured by this theme was the extent to which the NRC was identified as an educator. Participants revealed that the NRC was seen as a resource person who was there to assist them in the development of the necessary nursing research skills to deliver and evaluate best-practice. This encouraged and enabled participants to incorporate best-practice solutions into practice with confidence. The following statement demonstrated changes in one nurse's scholarly practice since involvement in the introduction of the collaborative partnership in research:

> It's given me lots more understanding about reading research papers and critiquing them and then trying to work that into my practice in any ways I can fit it in.

Participants also stated that they read more and frequently utilised the Internet for information. Whilst it is difficult to say whether this pursuit of information was due to the collaborative model, one nurse's comment reflects the interest created by the collaborative appointment (NRC):

> I know I'm trying to keep a bit more up-to-date and I have the Internet at home and I read up some of the articles on the Internet on health, and I just read more than I did before.

As an adjunct, the Journal Clubs were also seen to be of great benefit and an important forum for the dissemination of the most current research and discussion of its clinical relevance or applicability. The influence of the Journal Clubs was expressed by several participants with statements such as:

> Yes, I think I use research an awful lot more and I quote research an awful lot more to some of the clients. Especially in this area, because they are really up on research and the latest things and I have gone away and looked up some research for some of the mums on breastfeeding and some issues that relate to that. So from that point of view I have (changed my practice) and also having been in the Journal Club critiquing articles more I'm much more aware of how to do that now.

As indicated above, one participant noted that her knowledge regarding lactation issues had been challenged by dissemination of research within the Journal Clubs, which led to her improved professional development regarding lactation management. Thus, this participant commented directly on changes in her knowledge base since implementation of the collaborative initiative.

Another CHN summed up her perception of how specific Journal Club activity had influenced her clinical practice:

> Yes, I think it definitely has [improved my knowledge base], there have been some very interesting articles that the NRC has come out with, that we've read, and also lots [about the] LAP program [Lactation Advisors Package],

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 189

> and just the information that we've gathered on breastfeeding [an audit project] ...

Job satisfaction and self-confidence

Five of the six nurses expressed satisfaction with their job at the time of the evaluation. This did not appear to be entirely related to the Model, although the collaborative partnership seemed to contribute to participants' subjective self-confidence.

Encompassed under this theme was the extent to which participants felt nursing management were supportive of their professional education and pursuit of best-practice solutions. A community health nurse summed up her perception of how management contributed to her job satisfaction and self-confidence:

> ... management always gives me positives and this in turn makes you feel a lot better and increases your own understanding of what you're doing and how much difference your making.

Other participants discussed the collaborative partnership and the Model in terms of how it enabled them to quote from the research and provided a rationale for practice, which in turn improved their confidence in their practice generally. This was evident in the following statement:

> I think it has probably given me a few more ... a basis on what I'm telling people that I can tell people that this is based on a research study in this area, and I can quote things from different papers that I have been able to read since we've had these research models [PRM] so yes, my self-confidence in that area probably has increased.

Situational opportunity

This theme captured the extent to which some participants were not satisfied with the collaborative partnership and the PRM and echoed the negative or critical findings in Part one. For example, some participants considered the restricted availability of the NRC (0.2 FTE) not flexible enough to accommodate their needs, which was a hindrance and a source of frustration to their involvement in research.

This theme identified the perception that the NRC was focused on nursing research priorities in areas other than their immediate speciality, as suggested by the following comments:

> ... being outside the major stream that she was focusing on to start with but I understand the importance of it and we are all in agreement with it ...

> ... in the area I work I find we haven't got anything because we are so small ...

This theme also identified a lack of time and being too busy as reasons for not participating. For example, two community nurses had experienced no direct contact with the NRC due to time constraints in the past two years.

The emergence of this theme from the data supports the negative comments elicited during Part one of the evaluation and appears to suggest that some CHNs do not fully understand the PRM and its operational framework. However, it also suggests that the Model is not immune to being unduly influenced by the needs of mainstream programs.

Limitations

This evaluation was not without limitations. Of significance, the small number of CHNs interviewed means that a limited perspective of the Model and the collaborative partnership was revealed in the data. In addition, the wording on the evaluation form and questions on the interview schedule indicates a potential for bias as there was an assumption of prior knowledge of the partnership. It should be remembered, however, that the participants in Part Two were purposively selected based on either a positive or negative response set to questions about the partnership and Model. Perhaps of greater

importance is that the questions used in Part Two appeared to force an association between the specific variables of interest (e.g., Q11–13) and the Model, rather than allowing any association to emerge. In addition, no attempt was made to objectively measure the variable of job satisfaction and self-confidence at anytime; hence attributing a causal relationship between current subjective job satisfaction, self-confidence and the collaborative partnership is tenuous. Hence, interpretation of this theme remains subjective.

Discussion

The results of the evaluation presented in Section Two of this paper are similar to the cited literature that supports the utility of such collaborations (Gerrish, 2004; Wallin et al., 2003), and in particular the PRM (Chapman & Combs, 2005). It is not surprising, therefore, that the three themes to emerge from the evaluation were: (1) advancement of learning; (2) job satisfaction and self-confidence; and (3) situational opportunity.

As noted by Chapman and Combs (2005) and Wallin et al. (2003) there is also support in the literature for a Nurse Research Consultant position to educate nurses in the skills necessary to critique the literature, assess the clinical applicability of existing research and to conduct research and incorporate best-practice solutions into clinical practice. Therefore, it is also not surprising that these issues were emphasised in the theme of advancement of learning and that they were associated with subjective feelings of job satisfaction and self-confidence. Interestingly, little evidence emerged from the data concerning the specific contribution of the Model to quality improvement, although, this issue was alluded to throughout the responses.

The community health nurses who participated in this evaluation also identified lack of time and mainstream research priorities to be significant reasons to their non-participation in research activities and for not utilising research in their practice. The former findings are similar to those of Crawford et al. (2002) when they interviewed community mental health nurses and Retsas (2000) who interviewed 400 Australian nurses. However, the latter suggests that the collaborative partnership and the PRM are not immune to the influence of mainstream research priorities or perhaps priorities identified under strategic plans.

In spite of these limitations, this evaluation highlighted the importance of the collaborative partnership between the university and the community health service for the majority of participants. Indeed, the generally supportive perceptions reported regarding the Model and the collaborative partnership suggests that there has been a substantial change in the cultural attitude of CHNs since the previous evaluation, where many nurses reported that they did not think research had a place in clinical practice (Downie et al., 2001).

However, the results of this evaluation also revealed some significant areas for improving the operational performance of the Model, in particular in ensuring that all nurses across all streams have the same opportunity to access elements of the Model (e.g., Journal Clubs, NRC). Further, in light of the tentative finding that negative perceptions regarding research were more typical of older and hospital-based trained nurses, the results suggest that there is a need for specific attention to be given to this group to overcome their barriers to participation in research activity and best-practice solutions. As noted by McWilliam et al. (1997) to advance the discipline and profession of nursing, it is recognised that both clinicians and nurse academics must work closely together and make every effort to overcome the barriers and promote such important collaboration.

In conclusion, the results of this evaluation of a strategic collaborative Model of nursing practice suggest that collaborative partnerships have the potential to impact nurses' understanding of

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 191

the role of research in clinical practice and, perhaps more importantly, can result in greater confidence in their own ability to engage in research activities and in utilising research in their practice. However, the results also suggest that the operational performance of collaborative models need continual monitoring to ensure that all nurses, regardless of their educational background or employment focus, have equitable access opportunities.

References

Acorn S (1990): Joint appointments: Perspectives of nurse executives. *Canadian Journal of Nursing Administration* 3(4): 6–9.

Acorn S (1991): Relationship of role conflict and role ambiguity to selected job dimensions among joint appointees. *Journal of Professional Nursing* 7(4): 221–227.

Beitz JM & Heinzer MM (2000): Faculty practice in joint appointments: implications for nursing staff development. *The Journal of Continuing Education in Nursing* 31(5): 232–236.

Boswell C & Cannon S (2005): New horizons for collaborative partnerships. Nursing World', *Online Journal of Issues in Nursing* 10(2): available from http://www.nursingworld.org/ojin/topic26/tpc26_2.htm.

Burnard, P (1991): A method of analysing interview transcripts on qualitative research. *Nurse Education Today* 11: 461–466.

Campbell M & Taylor JR (2000): Academic and clinical collaboration. *Contemporary Nurse* 9: 211–219.

Chapman R & Combs S (2005): Collaboration in the Emergency Department: an innovative approach. *Accident and Emergency Nursing* 13: 63–69.

Crane S (1989): Joint appointments: the Deakin experience. *Journal of Advanced Nursing* 6(3): 21–25.

Crawford P, Brown B, Anthony P & Hicks C (2002): Reluctant empiricists: community mental health nurses and the art of evidence-based practice. *Health and Social Care in the Community* 10(4): 287–298.

Donnelly G, Warfel W & Wolf Z (1994): A faculty-practice program: three perspectives. *Holistic Nursing Practice* 8(3): 71–80.

Downie J, Orb A, Wynaden D, McGowan S, Zeeman Z, & Ogilvie S (2001): A practice–research model for collaborative partnership. *Collegian* 8(4): 27–32.

Dufault M (2004): Testing a Collaborative Research Utilization Model to translate best practices in pain management. *Worldviews on Evidence-Based Nursing* 1(1): s26–s32.

Dunn SV & Yates P (2000): The roles of Australian chairs in clinical nursing. *Journal of Advanced Nursing* 31(1): 165–171.

Gaskill D, Morrison P, Sanders F, Forster E, Edwards H, Fleming, R & McClure S (2003): University and industry partnerships: Lessons form collaborative research. *International Journal of Nursing Practice* 9: 347–355.

Gerrish K & Clayton J (2004): Promoting evidenced-based practice: an organizational approach. *Journal of Nursing Management* 12: 114–123.

Hutelmyer C & Donnelly G (1996): Joint appointments in practice positions. *Nursing Administration Quarterly* 20(4): 71–79.

Kelly K, Gardner D, Johnson, M, Maas M, McCloskey J, Bowers M, Maske J, Mallis S, Specht J & Watson C (1990): Adjunct executive appointments for faculty: An innovation in nursing collaboration. *Journal of Nursing Education* 20(10): 35–42.

Lathlean J (1992): The contribution of lecturer practitioners to theory and practice in nursing. *Journal of Clinical Nursing* 1(5): 237–42.

LeGris J, Weir R, Browne G, Gafni A, Stewart L & Easton S (2000): Developing a model of collaborative research: the complexities and challenges of implementation. *International Journal of Nursing Studies* 37: 65–79.

Magyary DL & Brandt P (2005): A leadership training model to enhance private and public service partnerships for children with special

CNJ_20_2_internal.qxd 26/11/2005 9:47 AM Page 192

healthcare needs. *Infants & Young Children* 18(1): 60–72.

Mallik M & Aylott E (2005): Facilitating practice learning in pre-registration nursing programmes – a comparative review of the Bournemouth Collaborative Model and Australian models. *Nurse Education in Practice* 5: 152–160.

McKenna B & Roberts R (1998): Joint appointment: Bridging the rift between nursing theory and practice through collaboration. *Proceedings of the 24th Conference of the Australian and New Zealand College of Mental Health Nurses Inc*. Promaco Conventions Pty Ltd Western Australia.

McWilliam CL, Desai K & Greig B (1997): Bridging town and gown: Building research partnerships between community-based professional providers and academia. *Journal of Professional Nursing* 13(5): 307–315.

Orb A (1999): *Optimising health care outcomes: A review of the partnership model. Nursing Conference for Health Care Professionals*. Centre for Nursing Research & Development in Collaboration with Major teaching Hospitals. Feb/99. Bentley, Western Australia.

Pillar B & Solem G (1999): Cooperation and collaboration for clinical nursing research. *Orthopedic Nursing* 18(2): 54–57.

Retsas A (2000): Barriers to using research evidence in nursing practice. *Journal of Advanced Nursing* 31(3): 599–606.

Spross JA (1989): The CNS as collaborator, in: Hamric AB & Spross JA (eds.) *The clinical nurse specialist in theory and practice*, 2nd edn, pp. 205–226, W.B. Saunders Co., Philadelphia.

Rusmussen D (1984): Joint appointment: A staff nurse's view. *Journal of Nursing Education* 23(6): 267–269.

Wallin L, Boström A-M, Wikblad K & Ewald U (2003): Sustainability in changing clinical practice promotes evidenced-based nursing care. *Journal of Advanced Nursing* 41(5): 509–518.

ANNOUNCING

ADVANCES IN CONTEMPORARY GENERAL PRACTICE NURSING

Guest Edited by Patricia Davidson and Elizabeth Patterson

ISBN 0-9757710-3-5; iv + 140 pages; softcover

A special issue of *Contemporary Nurse* – February 2007

Articles are invited on the role of the practice nurse, the health system, practice nurse education, practice nurse management issues, organisational culture, medico-legal issues, workforce regulation, medical indemnity and professional recognition

DEADLINE FOR MANUSCRIPT SUBMISSIONS: 30 JUNE 2006

Authors should indicate in their cover email that it is for the **Special Issue of *Contemporary Nurse* on General Practice Nursing**. Please direct all submissions to editorial@contemporarynurse.com following the guidelines on http://www.contemporarynurse.com/author_guidelines.php

eContent Management Pty Ltd, PO Box 1027, Maleny QLD 4552, Australia
Tel.: +61-7-5435-2900; Fax. +61-7-5435-2911; subscriptions@e-contentmanagement.com
www.e-contentmanagement.com

health care across the lifespan

AIMS AND SCOPE

Contemporary Nurse: Health care across the lifespan is an independently published, peer-reviewed journal designed to increase nursing skills, knowledge and communication, assist in professional development and to enhance educational standards by publishing stimulating, informative and useful articles on a range of issues influencing professional nursing research, teaching and practice. The journal welcomes:

- Original research, feature articles, clinical practice and topic reviews relevant to nursing research, teaching, health care practice and public health policy;
- Clinical Practice and Practice Protocol articles;
- Community Nursing and Social Work Practices;
- Nursing Management, Economics and Finance;
- Methodology advances and applications of value to researchers, teachers and practitioners;
- Literature Reviews, including those from graduate theses, that bring new or neglected areas into focus;
- Undergraduate students' well-graded papers that contribute to nursing knowledge and education (*Students' Corner* section) as commended by lecturer;
- Short articles presenting viewpoints on current issues in nursing (*Soapbox/Opinion* section);
- Brief descriptions of nursing practice or experiences that have made a critical difference (*Exemplar* section);
- Relevant book, journal and software reviews; and
- Notices on upcoming events such as conferences (*Noticeboard* section – free weblisting).

Please submit ALL manuscripts electronically to editorial@contemporarynurse.com, following the Author Guidelines on www.contemporarynurse.com.

MANUSCRIPT REVIEW PANEL

Contemporary Nurse has a dynamic database of nursing experts who review submitted manuscripts. Each published manuscript has been reviewed by at least two anonymous experts in the same field as the topic and research methodology. If you would like to join our panel of reviewers, please e-mail your curriculum vitae to the Publisher at editorial@contemporarynurse.com, including your area of expertise. We welcome international reviewers.

SUBSCRIPTIONS

Volumes 19–21 (three volumes in six issues of approx. 144 pages) will appear in the subscription year July 2005 – June 2006. Double issues will appear from time to time to ensure that publication delays are kept to a minimum. Print subscribers to *Contemporary Nurse* Volumes 19–21 are eligible to receive *Contemporary Nurse* Volumes 10–21 online for a small surcharge (see below). Prices for Volumes 19–21 are:

TERRITORIES

- North America, Europe, North East Asia & Middle East – airmail: institutional subscriptions, US$550.00; individual subscriptions, US$148.50.
- Australia, New Zealand, Pacific, China, South & South East Asia, South America & Africa – airmail: institutional subscriptions, AU$550.00; individual subscriptions, AU$148.50; incl. 10% GST for Australian subscribers.
- Discounts are available for Students if special issues are prescribed as course readers and ordered in bulk through an educational institution/bookshop.
- Discounts on Backsets of volumes from 2000 (Volume 9) are available to new subscribers.
- The publisher will honour one claim per subscription year for a missing issue if filed within six months of the publication date of that issue.

All large subscription agencies represent *Contemporary Nurse*. Renewals follow the Australian financial year. *Contemporary Nurse* is available online to print subscribers through Extenza: Volume 10 (2001) to Volume 21 (2006) will be provided against payment of a surcharge US$220 and AU$220 by territory, respectively. Pay per View (PPV) for individual articles and multicampus licensing arrangements are available. Library ISP addresses are required by the Publisher.

Subscriptions are payable in advance; subscription agents are invited to apply to the Publisher for discounts on larger orders. Cheques should be made payable to eContent Management Pty Ltd and sent to:

Contemporary Nurse
PO Box 1027, Maleny
QLD 4552, Australia

E-mail: subscriptions@e-contentmanagement.com
Telephone: +61-7-5435 2900
Facsimile: +61-7-5435 2911
www.contemporarynurse.com

ISSN 1037–6178