

University of Wollongong

Research Online

Faculty of Science, Medicine and Health -
Papers: Part B

Faculty of Science, Medicine and Health

2020

Lifestyle risk factor communication by nurses in general practice: Understanding the interactional elements

Sharon James

University of Wollongong, smj774@uowmail.edu.au

Susan McInnes

University of Wollongong, smcinn@uow.edu.au

Elizabeth J. Halcomb

University of Wollongong, ehalcomb@uow.edu.au

Jane L. Desborough

University of Wollongong

Follow this and additional works at: <https://ro.uow.edu.au/smhpapers1>

Publication Details Citation

James, S., McInnes, S., Halcomb, E. J., & Desborough, J. L. (2020). Lifestyle risk factor communication by nurses in general practice: Understanding the interactional elements. Faculty of Science, Medicine and Health - Papers: Part B. Retrieved from <https://ro.uow.edu.au/smhpapers1/1054>

Research Online is the open access institutional repository for the University of Wollongong. For further information contact the UOW Library: research-pubs@uow.edu.au

Lifestyle risk factor communication by nurses in general practice: Understanding the interactional elements

Abstract

Aim: This paper seeks to explore general practice nurses' perceptions of interactional factors supporting communication with patients about lifestyle risk. **Design:** Qualitative descriptive study embedded in a concurrent mixed methods design. **Methods:** Fifteen Australian general practice nurses were interviewed following video-recorded chronic disease management consultations between August 2017 - March 2018. **Results:** The theme of 'Interactional Factors' comprised of the subthemes 'Relational factors' and 'Patient factors'. Relational factors referred to communication techniques and methods supporting temporal continuity with patients about lifestyle risk. Patient factors included consumers' motivation, willingness, and readiness to prioritize lifestyle changes. Lack of awareness of the nurses' role was perceived to have an impact on initiation of lifestyle risk conversations. **Conclusion:** Strategies optimizing continuity of nursing care enhance the capacity for lifestyle risk reduction conversations with patients. Ongoing training in patient-centred communication and increasing patients' awareness of general practice nurses' roles would also better support these discussions. **Impact:** This research identifies ways the general practice nurses' role in supporting lifestyle risk reduction can be improved. Optimizing the general practice nurses' role in lifestyle risk communication can enhance the behaviour change and chronic disease management.

Publication Details

James, S., McInnes, S., Halcomb, E. & Desborough, J. (2020). Lifestyle risk factor communication by nurses in general practice: Understanding the interactional elements. *Journal of Advanced Nursing*, 76 (1), 234-242.

Lifestyle risk factor communication by nurses in general practice: understanding the interactional elements

ABSTRACT

Aim: This paper seeks to explore general practice nurses' perceptions of interactional factors supporting communication with patients about lifestyle risk.

Design: Qualitative descriptive study embedded within a concurrent mixed methods design.

Methods: Fifteen Australian general practice nurses were interviewed following video recorded chronic disease management consultations between August 2017 and March 2018.

Results: The theme of 'Interactional Factors', comprised of the subthemes 'Relational factors' and 'Patient factors'. Relational factors referred to communication techniques and methods supporting temporal continuity with patients about lifestyle risk. Patient factors included consumers' motivation, willingness and readiness to prioritise lifestyle changes. Lack of awareness of the nurses' role was perceived to have an impact on initiation of lifestyle risk conversations.

Conclusion: Strategies optimising continuity of nursing care enhance capacity for lifestyle risk reduction conversations with patients. Ongoing training in patient-centred communication and increasing patients' awareness of general practice nurses' roles would also better support these discussions.

Impact. This research identifies ways the general practice nurses' role in supporting lifestyle risk reduction can be improved. Optimising the general practice nurses' role in lifestyle risk communication can enhance behaviour change and chronic disease management.

Key words: Counseling, general practice, interactions, lifestyle, nursing, patient relations, primary care, qualitative descriptive, thematic analysis

1. INTRODUCTION

Due to increases in the aging population and chronic disease burden, presentations in general practice are more complex and many patients present with at least one chronic condition (Baird, Charles, Honeyman, Maguire, & Das, 2016; Britt et al., 2016; World Health Organization, 2018). Lifestyle risk factors such as smoking, poor nutrition, harmful alcohol intake and inadequate physical activity are known causes of chronic conditions such as hypertension, type 2 diabetes, obesity and cancers (World Health Organization, 2017). Proactive primary prevention measures, such as lifestyle risk reduction, have great potential in general practice to reduce this disease burden (Boyce, Peckham, Hann, & Trenholm, 2010). However, to date, general practice has been criticized for its efforts to redress the chronic disease burden (Swerissen, Duckett, & Wright, 2016).

Internationally, general practice nurses (GPNs) provide an important role in chronic disease management (CDM), including activities that support disease prevention and patient self-management (Carrington et al., 2016; Eley et al., 2013). Despite variability in international primary care settings, many countries including Australia, New Zealand and the UK have targeted funding and policy initiatives to enhance the number and develop the roles of GPNs to meet increasing patient need (Australian Medicare Local Alliance, 2012; Ministry of Health, 2018; Primary Care Workforce Commission, 2015; Swerissen et al., 2016). Despite this, shortcomings exist in how GPNs are supported to work to their full scope of practice (Desborough et al., 2016; Halcomb, Ashley, James, & Smyth, 2018).

In Australia, the GPN role includes health promotion, disease prevention, acute treatment, health education and CDM (Australian Primary Health Care Nurses Association, 2017; Halcomb et al., 2018). Patients generally understand that GPNs can competently support them to manage their chronic conditions (Halcomb, Davies, & Salamonson, 2015a; Halcomb, Salamonson, & Cook, 2015b; Young, Eley, Patterson, & Turner, 2016). General practice nurse initiated lifestyle risk communication occurs

both opportunistically and part of government funded CDM (The Department of Health, 2017).

However, the initiation and conduct of lifestyle risk communication in clinical practice is dependent on factors such as the individual nurse, consumer and context of care (James, Halcomb, Desborough, & McInnes, 2019).

1.1 Background

Addressing lifestyle risk behaviours is complex, involving issues such as the globalization of unhealthy diets and lifestyles, supported by poor policy development and urban planning (World Health Organization, 2018). Supporting patients in lifestyle risk reduction requires both patient commitment and health practitioner support (Mason & Butler, 2010; World Health Organization, 2017). Power dynamics amongst and between health professionals and patients adds to this complexity (Jolanki & Tynkkynen, 2018). Creating an environment where conversations about lifestyle risk reduction can occur is important for patients to build the confidence to undertake behaviour change (Mason & Butler, 2010).

Remembering personal goals and absorbing information when presenting for consultations requires mental energy (Henselmans, Heijmans, Rademakers, & van Dulmen, 2015). Patients with complex needs are particularly vulnerable and engagement can be problematic at times of impairment, illness, poor health literacy or means to make improved health choices (Jolanki & Tynkkynen, 2018). This problem is further exacerbated through fragmented health provider collaboration and consultation time constraints, limiting patient engagement, choice and informed decision making (Dixon et al., 2010; Lawn, Delany, Sweet, Battersby, & Skinner, 2015).

Communication about lifestyle risk reduction is a collaborative process whereby GPNs can support patients to consider opportunities for behaviour change and develop personal strategies to improve health (Mason & Butler, 2010; Noordman, van der Weijden, & van Dulmen, 2012). Components of this process include rapport building, agenda setting, assessing importance, confidence and readiness,

information exchange and reducing resistance (Mason & Butler, 2010). Specific behaviours within nurse-patient interactions support therapeutic relationships such as active listening, a relaxed ambience, approachability, a personalized approach, time, and trust (Desborough et al., 2018; Girard, Hudon, Poitras, Roberge, & Chouinard, 2017; Young et al., 2016). Therapeutic relationships formed through collaboration between patients and GPNs enable patients to better manage their health (Desborough, Banfield, Phillips, & Mills, 2017; Young et al., 2016).

Interactional factors supporting rapport and approachability are multidimensional. They include environmental, nurse and patient related factors such as mutual participation, supportive working conditions, patients' ability to see the computer screen, body language, cultural and language needs, room ambience and privacy (de Rezende et al., 2015; Duke, Frankel, & Reis, 2013; Kettunen, Poskiparta, & Gerlander, 2002; Norouzinia, Aghabarari, Shiri, Karimi, & Samami, 2015). While communication is significantly influenced by interactional factors (de Rezende et al., 2015; Kristjansson et al., 2013; Lawn et al., 2015), little is known about how these interactional factors contribute to lifestyle risk communication between GPNs and patients in the general practice setting.

2. THE STUDY

2.1 Aim

The aim of this paper is to explore GPNs' perceptions of interactional factors that support communication with patients about lifestyle risk.

2.2 Design

This paper reports on a single theme that emerged from the qualitative descriptive interviews undertaken within a larger concurrent mixed methods project exploring the perceptions of, and approaches used for lifestyle risk communication by registered nurses in Australian general practice.

The quantitative component comprised non-participatory video recording of GPN CDM consultations

(Authors own under review). A qualitative descriptive approach was chosen to underpin the qualitative component, to link knowledge closely to the clinical experience of participants (Neergaard, Olesen, Andersen, & Sondergaard, 2009). Given the large volume and depth of data generated, other components of the project been reported in separate publications (Authors own under review).

2.3 Participants

Convenience sampling was used to recruit 15 Baccalaureate prepared, registered nurses (GPNs) employed in general practices in the South Eastern New South Wales Primary Health Network (SENSWPHN) and Australian Capital Territory Primary Health Network (ACTPHN), Australia. Registered nurses were the target group as they represent the largest proportion of the GPN workforce (Australian Primary Health Care Nurses Association, 2018). Participants were recruited via phone calls and emails to general practices in the study area, and newsletters and communications disseminated by professional networks such as the Australian Primary Health Care Nurses Association (APNA), SENSWPHN and ACTPHN. Participants initially took part in the video observation and then were interviewed by the researcher.

2.4 Data collection

Participants were individually interviewed by the primary investigator (PI) (SJ) either face-to-face or via telephone depending on their location. Rapport had been built with participants during the recruitment and conduct of the video-observation aspect of the study. Participants were aware that the PI was an experienced general practice nurse and so had a level of insider knowledge of their experiences.

Patient and GPN demographic information were collected prior to interview. Open-ended questions, with additional prompts, were related to perceptions of lifestyle risk communication in GPN consultations (Figure 1). Interviews were audio recorded and field notes were kept. Fifteen interviews,

which included all GPN participants, were conducted. It was thought that data saturation was achieved at 13 interviews, however, the remaining two participants were also interviewed to confirm that saturation had been achieved.

2.5 Ethical considerations

This study was approved by the University of Wollongong Human Research Ethics Committee (Approval No. 2016/381). Participation was voluntary with written consent obtained prior to interviews. Confidentiality and anonymity were assured through coding of participants prior to transcription, and use of pseudonyms in publications. Use of a professional transcription service ensured that ethical data management was maintained.

2.6 Validity and reliability/Rigour

Trustworthiness and quality was established through Lincoln and Guba (1985) steps of credibility, transferability, dependability, confirmability and authenticity. Data segments were sorted, categorized, summarized and then organized into labels, and themes by the PI. All authors reviewed verbatim transcripts and discussed coding and the themes until consensus was reached. Credibility of the data was established through diverse sampling (inner and outer regional areas, as well as a major city), the use of field notes, and confirming saturation. Ongoing reflexivity also supported this. In the study's context, transferability was achieved through examining interview data in the context of confirming evidence from other sources in the same study, which also included recruitment from rural and urban settings and a mix of small business and corporate practices. Open and frank communication during the review of transcripts and thematic interpretations between the research team ensured dependability. Confirmability was established through linking interpretations with participants' quotes. Lastly, authenticity was demonstrated through verbatim transcriptions of the audio recordings and field notes.

2.7 Data analysis

Verbatim transcription was undertaken by a professional transcription company and then uploaded into NVivo Version 11 for analysis (QSR International Pty Ltd., 2017). The research team comprised of a doctoral candidate (SJ) and three doctorally qualified nurses who have experience in qualitative primary care research. The PI verified accuracy of the transcripts by listening to the audio recordings and comparing them to the transcripts. Thematic analysis was based on the steps outlined by Braun and Clarke (2006), ensuring analysis was grounded in data - including data familiarisation, generation of codes, collation of themes, thematic review, theme definition and reporting. Familiarisation occurred through immersion in the recordings and transcripts, and consideration of GPNs' views of lifestyle risk communication with their patients. Coding identified the features or segments of data needed for the generation of themes, which were derived from the predominant view of the related codes. Subthemes were identified within these. Authors agreed on the themes, which were reviewed, defined, refined and verified through selecting verbatim quotes to demonstrate accuracy and consistency. These discussions also involved reflecting on the biases of individual team members and the impact that this might have had on their interpretation of the data.

3. FINDINGS

3.1 Participant characteristics

Fifteen GPNs were recruited from 14 general practices. Participants were all female and aged between 25-66 years (mean 43.4 years; SD 11.4 years). Three GPNs (20%) initially qualified outside of Australia and just over half held a Bachelor degree as their highest level of education (n=8; 53.3%). Participants had worked as a registered nurse for 2-35 years (mean 15.9 years; SD 9.3 years) and had worked in general practice for 1-18 years (mean 7.4 years; SD 5.2 years). The duration of interviews ranged from 16.3-36.0 minutes (mean 24.3 minutes).

3.2 Thematic structure

The first of two sub-themes, *relational factors*, describes the communication strategies and relational continuity perceived necessary for lifestyle risk communication. Participants described a mix of communication strategies that indicated the use of person-centred or approaches that used scare tactics. Person-centred strategies included active listening, giving palatable amounts of information and understanding patient communication needs. They described relational continuity, which required the development of familiarity and rapport, and specific strategies related to these that supported lifestyle risk communication. Examples of scare tactics described poor outcomes of chronic disease, such as leg amputation, should the patient not prioritise lifestyle risk reduction.

The second sub-theme, *patient factors*, describes readiness for behaviour change and lack of awareness of the GPN role as having an impact on lifestyle risk communication. Participants believed that motivation and willingness indicated patient prioritisation to make lifestyle changes. Patients' lack of knowledge about reasons for seeing GPNs and their role in patient care were seen to affect interactions and their readiness for lifestyle risk reduction conversations.

3.2.1 Relational factors

Communication strategies

Participants described a variety of approaches to lifestyle communication. Some described how they "... really try to make it patient-led. Because otherwise we're on my agenda and not theirs" (Kate).

However, others described using scare tactics:

" well I sort of tell them that, you know, if you don't do this, then that's going to happen to you. I sort of give them the worst-case scenario of what can happen if you don't get your diabetes under control..., if you don't look after your feet or your eyes, you could go blind, or you - you know with your feet, you could get an infection that turns into an ulcer, that turns into an amputation. So, I kind of scare them." (Gloria)

Maintaining engagement, using different strategies, was seen as an important part of the communication process. Participants described gauging the patient's communication needs, listening and conversing in a "realistic" way:

"communication is the most important thing, I think, for when you're talking about lifestyle.... so rather than school them, I think. Try and meet them in a normal kind of realistic way they're a bit more onboard for listening to what you might have to say then thereafter." (Susan)

Gauging the patient's communication needs sometimes involved nurses adapting their communication style:

"... I think when you have a talk to them, it doesn't take very long to kind of figure out how the person wants to be spoken to about things. So, gauging their communication style too, which would style my communication to them.... " (Chrissie)

Strategies such as providing smaller amounts of information depended on nurses' perception of patients' capacity to consider GPN conversations about lifestyle risk and undertake lifestyle risk reduction activities:

" So if they're quite obviously someone who drinks a lot, smokes a lot, is overweight, then we don't want to bombard with too much....So we do try to find the one or twolittle things that they could aim to focus on. " (Tina)

Relational continuity

The use of phrases such as "chipping away" (Stevie) and "digging away" (Nancy) featured in some participants' dialogue evidenced their unique continuing relationship with the patients as well as a perceived need for an ongoing discussion about lifestyle risk factors. Some, like Stevie, identified that this approach came "as I've gotten more experienced."

An ongoing nurse-patient relationship was seen to support temporal continuity of discussions about lifestyle risk through familiarity and time spent together:

"I think they generally feel more comfortable with a nurse. I guess because they've had contact with them in the past one on one they talk better and they've got more time with you as well." (Diana)

Being approachable and maintaining “a little bit of rapport” (Pat) with patients was seen as necessary for ongoing relationships and effective communication about lifestyle risk. Without rapport and trust, Janet recognized that “I could say whatever I wanted to and it wouldn't work.” Rapport was also valued for supporting open dialogue about lifestyle risk reduction successes as well as failures, and maintaining therapeutic relationships for ongoing lifestyle behaviour change support:

"Everybody slips, everybody slips. I'm not there to wave a finger or a whip at anybody. I'd rather they had a happy rapport that we could talk about anything, even when it's gone bad for them." (Kim)

3.2.2 Patient factors

Readiness for behaviour change

Successful discussions about lifestyle risk were seen to be dependent on patients' readiness and capacity to prioritise lifestyle changes. Pat indicated that being “too pushy” did not assist lifestyle risk reduction, as the patient may not be “ready to take it up”:

"It's what it is that they're after at the time. That's important. What the person wants to know and learn, what their questions are, rather than me just going, blah, allow them to bring up bits and pieces, and then jump on leads and go with it from there." (Joan)

Motivation was perceived as necessary for lifestyle risk reduction readiness, which sometimes occurred when patients were “newly diagnosed with something” (Tina). For others:

“...some people are quite motivated and they will come and see you because they are very ready to do something about whatever it is.....some are just there because they want their five visits to the podiatrists to get their feet done for the year. That’s all they really want and they don’t really want to do anything else.” (Pat)

Few participants overtly discussed strategies for resolving barriers, preferring to discuss lifestyle risk reduction if the patient indicated willingness to do so rather than “trying to push it down their throat” (Pat). Once this was ascertained, further discussions and encouragement could take place:

“So if you wanted to start a conversation about exercise, they might talk a lot about pain and their barriers that are stopping them from doing things. That really depends on the person.” (Chrissie)

“...if you get the patient on board with something that's important to them at that current space of time, they're generally more encouraged and likely to make the necessary adjustments within lifestyle or diet or management and keep them on board and keeps them enthused with regards to that.” (Susan)

Lack of awareness of the GPN role

Some participants reflected on experiences when the patients were unaware of GPNs’ role in CDM consultations. The need for communication regarding this was seen as one way to enhance patients’ readiness to receive health education and lifestyle risk reduction advice within GPN CDM consultations. This involved educating the patient about the referral process prior to consultation, either by the GPN, general practitioner or reception staff. This awareness of the GPNs’ CDM role potentially had an impact on the content of interactions, including patients’ readiness for conversations about lifestyle risk reduction:

“the patient comes in here and hasn't got a clue why they're here, which seriously annoys me because then I get to do all the explaining” (Kim).

“They don't know why the doctor's booked them in with us or why we've asked them to come in. Sometimes they are - sometimes they're just a bit suspicious, why are we asking all these questions. We just need to set a parameter around why we're doing it and the benefits that we're trying to achieve from it.” (Tina)

“some of them have no idea, and some of them think I'm a podiatrist, I'm the dietician.”
(Gloria)

DISCUSSION

Patients in general practice believe that the familiarity, shared decision making and every day styles of communication between nurses and patients optimise interactions (Barratt & Thomas, 2018). The findings of this study describe GPNs' perceptions of interactional factors that support lifestyle risk communication with patients, which similarly indicate the ongoing, approachable and realistic ways of communication necessary for lifestyle risk conversations. Gauging patients' interactional needs and ability to prioritise content formed part of GPNs' adaptive communication strategy to maintain patient engagement in lifestyle risk reduction conversations.

Patients' emotional and relationship needs can require as much attention as information giving (Watson & Gallois, 1999). The behaviour and speech used by nurses, such as person-centred versus scare tactics, is known to influence patients' perceptions, responses and satisfaction with the therapeutic relationship (Baker & Watson, 2015; Siouta, Farrell, Chan, Walshe, & Molassiotis, 2019). Adopting scare tactics, focusing on diagnosis and poor clinical outcomes rather than the person, stems from power relationships and leads to poor patient involvement in care (Siouta et al., 2019). Accommodating communication in a person-centred way, such as listening and trying to understand patients' needs,

perspectives and strengths, enhances patients' willingness to have conversations about behaviour change (Baker & Watson, 2015; Mason & Butler, 2010). In this way, shared decision-making about lifestyle risk reduction is supported by an ongoing learning approach based on patients' readiness for behavior change (Mason & Butler, 2010; Siouta et al., 2019).

Relational factors such as rapport, familiarity and approachability were perceived as necessary for lifestyle risk reduction conversations. Continuing relationships contribute to the familiarity and enablement necessary to overcome barriers to behaviour change and self-management (Desborough et al., 2017; Kuo, Su, & Lin, 2018). In general practice, older patients and those presenting with multi-morbidity, as well as practitioners with more experience and long-standing relationships with their patients are more likely to experience relational continuity (Kristjansson et al., 2013). A study of nurse-led hypertension management demonstrated that patients appreciated communication with the GPN about lifestyle factors and the level of accountability that ongoing dialogue created (Stephen, Hermiz, Halcomb, McInnes, & Zwar, 2018).

Few participants discussed resolving barriers to behaviour change in their conversations with patients, preferring to wait until patients expressed willingness and motivation for lifestyle risk reduction. Discussing sensitive issues such as weight management can be problematic for nurses in general practice due to concerns about jeopardizing rapport (Brown & Thompson, 2007; Michie, 2007). However, both rapport building and barrier resolution are important components of behaviour change communication techniques, such as motivational interviewing (MI), and foster self-management (Coventry, Fisher, Kenning, Bee, & Bower, 2014; Mason & Butler, 2010). Organizational support, funding and ongoing education is required for GPNs to enact person-centred methods of lifestyle risk communication to optimise the effectiveness of lifestyle risk reduction conversations (James et al., 2019).

To ensure care integration, GPNs maintain collaborative relationships within and external to the practice (Halcomb, Stephens, Bryce, Foley, & Ashley, 2017). Despite other research indicating patient satisfaction and acceptability of the work of GPNs, participants indicated a perceived lack of patient awareness of the GPN role (Halcomb et al., 2015b; Hegney, Patterson, Eley, Mahomed, & Young, 2013). Communicating the value of the GPN role to patients, and in primary care teams, supports GPNs' visibility and understanding of these roles. Enhancing understanding of GPNs' skills, knowledge and responsibilities in patient care prior to consultations can redress time taken within the consultation and prepare patients for these appointments. This includes sharing information with patients around the aims and processes involved in CDM, supporting their involvement in care (Lawn et al., 2015). Mechanisms for improved CDM role visibility could take the form of GPN involvement in team meetings (McInnes, Peters, Bonney, & Halcomb, 2017) and in-services as well as practice or web based promotion of staff.

This research identifies ways lifestyle risk reduction can be improved. Knowledge about enhancing interactional elements of the GPNs' role has implications for patient outcomes as well as other settings where lifestyle risk communication occurs. Optimising the general practice nurses' role in lifestyle risk communication through strengthening education, policy and workplace support has potential in the management of chronic disease. Further research is needed to explore the content of lifestyle risk communication between patients and nurses.

Limitations

Participants in this study were also involved in the video-observation component of the larger mixed methods project, where CDM consultations were recorded. Nurses who were unwilling to be videoed, therefore, did not have the opportunity to present their perspectives through these interviews.

Additionally, it is possible that participants had a higher level of interest in chronic disease management and lifestyle risk prevention than those who declined. Participants were drawn from a

range of rural, regional and metropolitan areas, and employed in both a corporate chain and small business practices. However, given the nature of qualitative research it is not clear if the rurality or business model had an impact on the experience. Finally, this study represents only the perspectives of nurses. Exploring the patient perspective may provide additional insights and should be considered in future research.

CONCLUSION

Increases in the prevalence of chronic disease and patient complexity present both challenges and opportunities for nurses in general practice. Ongoing GPN-patient contact creates rapport and trust, supporting therapeutic relationships and conversations of lifestyle risk reduction. Knowing how to interact effectively with patients in a person-centred way is essential for lifestyle risk communication. This can be undertaken using established communication techniques, such as MI, and strategies in therapeutic communication such as active listening and assessing patients' communication needs. Ensuring GPNs have ongoing training and workplace support will better inform effective conversations of lifestyle risk; however, for these interventions to be effective, the role of GPNs needs to be better understood by patients.

Conflict of Interest statement

No conflict of interest has been declared by the authors.

References

- Australian Medicare Local Alliance. (2012). *General practice nurse national survey report* Retrieved from <http://healthypractices.apna.asn.au/wp-content/uploads/2015/03/General-Practice-Nurse-National-Workforce-Survey-2012.pdf>
- Australian Primary Health Care Nurses Association. (2017). What is Primary Health Care Nursing? Retrieved from <https://www.apna.asn.au/profession/what-is-primary-health-care-nursing>
- Australian Primary Health Care Nurses Association. (2018). APNA Workforce Survey 2018. Retrieved from <https://apna.asn.au/files/APNAWorkforceSurvey2018Summary.pdf>
- Baird, B., Charles, A., Honeyman, M., Maguire, D., & Das, P. (2016). *Understanding pressures in general practice*. London: The King's Fund.
- Baker, S. C., & Watson, B. M. (2015). How Patients Perceive Their Doctors' Communication: Implications for Patient Willingness to Communicate. *Journal of Language and Social Psychology, 34*(6), 621-639. doi:10.1177/0261927X15587015
- Barratt, J., & Thomas, N. (2018). Nurse practitioner consultations in primary health care: Patient, carer, and nurse practitioner qualitative interpretations of communication processes. *Primary Health Care Research and Development*. doi:10.1017/S1463423618000798
- Boyce, T., Peckham, S., Hann, A., & Trenholm, S. (2010). *A pro-active approach. Health promotion and ill-health prevention. An inquiry into the quality of general practice in England*. London: The King's Fund.
- Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology, 3*(2), 77-101.

- Britt, H., Miller, G., Henderson, J., Bayram, C., Harrison, C., Valenti, L., . . . Gordon, J. (2016). *General practice activity in Australia 2015-2016* (Vol. General practice series no. 40). Sydney: Sydney University Press.
- Brown, I., & Thompson, J. (2007). Primary care nurses' attitudes, beliefs and own body size in relation to obesity management. *Journal of Advanced Nursing*, *60*(5), 535-543. doi:10.1111/j.1365-2648.2007.04450.x
- Carrington, M. J., Jennings, G. L., Harris, M., Nelson, M., Schlaich, M., Stocks, N. P., . . . Stewart, S. (2016). Impact of nurse-mediated management on achieving blood pressure goal levels in primary care: Insights from the Valsartan Intensified Primary care Reduction of Blood Pressure Study. *European Journal of Cardiovascular Nursing*, *15*(6), 409-416. doi:10.1177/1474515115591901
- Coventry, P. A., Fisher, L., Kenning, C., Bee, P., & Bower, P. (2014). Capacity, responsibility, and motivation: A critical qualitative evaluation of patient and practitioner views about barriers to self-management in people with multimorbidity. *BMC Health Services Research*, *14*(1). doi:10.1186/s12913-014-0536-y
- de Rezende, R. e., de Oliveira, R. M., de Araújo, S. T., Guimarães, T. C., do Espírito Santo, F. H., & Porto, I. S. (2015). Body language in health care: a contribution to nursing communication. *Revista brasileira de enfermagem*, *68*(3), 430-436, 490-436". doi:10.1590/0034-7167.2015680316i
- Desborough, J., Bagheri, N., Banfield, M., Mills, J., Phillips, C., & Korda, R. (2016). The impact of general practice nursing care on patient satisfaction and enablement in Australia: A mixed methods study. *International Journal of Nursing Studies*, *64*, 108-119.

- Desborough, J., Banfield, M., Phillips, C., & Mills, J. (2017). The process of patient enablement in general practice nurse consultations: a grounded theory study. *Journal of Advanced Nursing*, 73(5), 1085-1096. doi:10.1111/jan.13199
- Desborough, J., Phillips, C., Mills, J., Korda, R., Bagheri, N., & Banfield, M. (2018). Developing a positive patient experience with nurses in general practice: An integrated model of patient satisfaction and enablement. *Journal of Advanced Nursing*, 74(3), 564-578.
doi:10.1111/jan.13461
- Dixon, A., Robertson, R., Appleby, J., Burge, P., Devlin, N., & Magee, H. (2010). *Patient choice. How patients choose and how patients respond*. London: The King's Fund.
- Duke, P., Frankel, R. M., & Reis, S. (2013). How to Integrate the Electronic Health Record and Patient-Centered Communication Into the Medical Visit: A Skills-Based Approach. *Teaching and Learning in Medicine*, 25(4), 358-365. doi:10.1080/10401334.2013.827981
- Eley, D. S., Patterson, E., Young, J., Fahey, P. P., Del Mar, C. B., Hegney, D. G., . . . Scuffham, P. A. (2013). Outcomes and opportunities: a nurse-led model of chronic disease management in Australian general practice. *Australian Journal of Primary Health*, 19(2), 150-158.
doi:10.1071/PY11164
- Girard, A., Hudon, C., Poitras, M. E., Roberge, P., & Chouinard, M. C. (2017). Primary care nursing activities with patients affected by physical chronic disease and common mental disorders: a qualitative descriptive study. *Journal of Clinical Nursing*, 26(9-10), 1385-1394.
doi:10.1111/jocn.13695
- Halcomb, E., Ashley, C., James, S., & Smyth, E. (2018). Employment conditions of Australian primary health care nurses. *Collegian*, 25, 65-71. doi:<http://dx.doi.org/10.1016/j.colegn.2017.03.008>

- Halcomb, E., Davies, D., & Salamonson, Y. (2015a). Consumer satisfaction with practice nursing: A cross-sectional survey in New Zealand general practice. *Australian Journal of Primary Health, 21*(3), 347-353. doi:10.1071/PY13176
- Halcomb, E., Stephens, M., Bryce, J., Foley, E., & Ashley, C. (2017). The development of professional practice standards for Australian general practice nurses. *Journal of Advanced Nursing, 73*(8), 1958-1969. doi:10.1111/jan.13274
- Halcomb, E. J., Salamonson, Y., & Cook, A. (2015b). Satisfaction and comfort with nursing in Australian general practice. *Collegian, 22*(2), 199-205. doi:10.1016/j.colegn.2014.09.003
- Hegney, D. G., Patterson, E., Eley, D. S., Mahomed, R., & Young, J. (2013). The feasibility, acceptability and sustainability of nurse-led chronic disease management in Australian general practice: The perspectives of key stakeholders. *International Journal of Nursing Practice, 19*(1), 54-59. doi:10.1111/ijn.12027
- Henselmans, I., Heijmans, M., Rademakers, J., & van Dulmen, S. (2015). Participation of chronic patients in medical consultations: patients' perceived efficacy, barriers and interest in support. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy, 18*(6), 2375-2388. doi:10.1111/hex.12206
- James, S., Halcomb, E., Desborough, J., & McInnes, S. (2019). Review: Lifestyle risk communication by general practice nurses: An integrative literature review. *Collegian, 26*, 183-193. doi:10.1016/j.colegn.2018.03.006
- Jolanki, O., & Tynkkynen, L. K. (2018). Primary health care nurses' views on patients' abilities and resources to make choices and take decisions on health care. *Health Policy, 122*(9), 957-962. doi:10.1016/j.healthpol.2018.07.008

- Kettunen, T., Poskiparta, M., & Gerlander, M. (2002). Nurse-patient power relationship: Preliminary evidence of patients' power messages. *Patient Education And Counseling*, 47(2), 101-113. doi:10.1016/S0738-3991(01)00179-3
- Kristjansson, E., Hogg, W., Dahrouge, S., Tuna, M., Mayo-Bruinsma, L., & Gebremichael, G. (2013). Predictors of relational continuity in primary care: patient, provider and practice factors. *BMC Family Practice*, 14(1), 72-80. doi:10.1186/1471-2296-14-72
- Kuo, C.-C., Su, Y.-J., & Lin, C.-C. (2018). A systematic review and meta-analysis: Effectiveness of internet empowerment-based self-management interventions on adults with metabolic diseases. *74*, 1787-1802. doi:10.1111/jan.13574
- Lawn, S., Delany, T., Sweet, L., Battersby, M., & Skinner, T. (2015). Barriers and enablers to good communication and information-sharing practices in care planning for chronic condition management. *Australian Journal of Primary Health*, 21(1), 84-89. doi:10.1071/PY13087
- Lincoln, Y., & Guba, E. (1985). *Naturalistic Inquiry*. California, United States of America: Sage Publications, Inc.
- Mason, P., & Butler, C. (2010). *Health Behavior Change; A Guide for Practitioners* (2nd ed.). United Kingdom: Churchill Livingstone Elsevier
- McInnes, S., Peters, K., Bonney, A., & Halcomb, E. (2017). Understanding collaboration in general practice: A qualitative study. *Family Practice*, 34(5), 621-626. doi:10.1093/fampra/cmz010
- Michie, S. (2007). Talking to primary care patients about weight: A study of GPs and practice nurses in the UK. *Psychology, Health & Medicine*, 12(5), 521-525. doi:10.1136/qshc.2004.011155
- Ministry of Health. (2018). *Health Workforce New Zealand: Annual Report to the Minister of Health 1 July 2016 to 30 June 2017*. Wellington: Ministry of Health.

- Neergaard, M., Olesen, F., Andersen, R., & Sondergaard, J. (2009). Qualitative description - the poor cousin of health research? *BMC Medical Research Methodology*, 9(52), 1-5.
- Noordman, J., van der Weijden, T., & van Dulmen, S. (2012). Communication-related behavior change techniques used in face-to-face lifestyle interventions in primary care: A systematic review of the literature. *Patient Education And Counseling*, 89(2), 227-244.
doi:<http://dx.doi.org/10.1016/j.pec.2012.07.006>
- Norouzinia, R., Aghabarari, M., Shiri, M., Karimi, M., & Samami, E. (2015). Communication Barriers Perceived by Nurses and Patients. *Global journal of health science*, 8(6), 65-74.
doi:10.5539/gjhs.v8n6p65
- Primary Care Workforce Commission. (2015). The future of primary care; Creating teams for tomorrow. Retrieved from [https://www.hee.nhs.uk/sites/default/files/documents/The Future of Primary Care report.pdf](https://www.hee.nhs.uk/sites/default/files/documents/The_Future_of_Primary_Care_report.pdf)
- QSR International Pty Ltd. (2017). NVivo qualitative data analysis Software.
- Siouta, E., Farrell, C., Chan, E. A., Walshe, C., & Molassiotis, A. (2019). Communicative constructions of person-centred and non-person-centred caring in nurse-led consultations. *European Journal of Oncology Nursing*, 40, 10-21. doi:10.1016/j.ejon.2019.02.008
- Stephen, C. M., Hermiz, O. S., Halcomb, E. J., McInnes, S., & Zwar, N. (2018). Feasibility and acceptability of a nurse-led hypertension management intervention in general practice. *Collegian*, 25(1), 33-38. doi:10.1016/j.colegn.2017.03.003
- Swerissen, H., Duckett, S., & Wright, J. (2016). *Chronic Failure in Primary Care*. Retrieved from <http://grattan.edu.au/wp-content/uploads/2016/03/936-chronic-failure-in-primary-care.pdf>

- The Department of Health. (2017). Best-practice examples of chronic disease management in Australia. Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-best-practice>
- Watson, B., & Gallois, C. (1999). Communication accommodation between patients and health professionals: themes and strategies in satisfying and unsatisfying encounters. *International Journal of Applied Linguistics*, 9(2), 167-180. doi:10.1111/j.1473-4192.1999.tb00170.x
- World Health Organization. (2017). Chronic diseases: causes and health impact. *Chronic Diseases and Health Promotion: Part Two. The Urgent Need for Action*. Retrieved from http://www.who.int/chp/chronic_disease_report/part2_ch1/en/index15.html
- World Health Organization. (2018). Ageing and health. Retrieved from <https://www.who.int/en/news-room/fact-sheets/detail/ageing-and-health>
- Young, J., Eley, D., Patterson, E., & Turner, C. (2016). A nurse-led model of chronic disease management in general practice: Patients' perspectives. *Australian Family Physician*, 45(12), 912-916.