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Nurse Practitioner Led Services in Primary Health Care in Rural NSW– Two Case Studies

Frances Barraclough

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Statement of authorship

This work has not been submitted for any other degree at the University of Sydney or any other educational institution. This thesis is the work of the candidate. It contains no material previously published or written by another person except where due acknowledgement is made in the thesis.

Frances Barraclough 

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Abstract

Background

Nurse Practitioners (NPs) are a relatively new advanced nursing role. It was hoped that NPs would reduce some of the challenges facing health care, address workforce shortages and improve access to services for rural populations. The most recent census of Australian NPs showed that just twelve of 208 working NPs were located in primary health care settings. It also showed the majority of NPs were employed in metropolitan areas. Few previous studies describe NP roles in detail, or in rural primary health care settings.

Aims

This study aims to describe, in detail, the roles of two NPs in rural New South Wales in primary health care settings. One case study focuses on the delivery of an integrated mental health service and the other on leadership in aged care.

Methods

A case study methodology was employed, using multiple data sources. Data were gathered using semi-structured interviews with 31 key stakeholders, the examination of key documentation, and observation of the NPs within these settings. In the first case study, quantitative data were also analysed. Interview data were analysed thematically.

Results

The case studies offer an in-depth description of why and how these roles were established, what the NPs do and their impact within the context of small rural towns. They illustrate how NPs established intersectoral partnerships, new service delivery models and advocacy regarding the way health care was provided. The case studies also provide valuable information on how to best incorporate NPs into rural primary health care.

Conclusion

This study details the complexity of two NP roles within rural primary health care settings. The two case studies show that in these settings, NPs are providing leadership, supporting other services, helping to address workforce shortages, improving access to services for rural populations, and therefore demonstrating the positive impact of NPs working in these settings.

Contents

Chapter 1. Introduction

This study uses a case study method to describe the role of two Nurse Practitioners (NP) located in primary health care settings in rural New South Wales (NSW). This chapter begins with an outline of the importance of the study, including a brief background, recognition and summary of current literature on the development of NPs in Australia, the purpose of the study, and the study design. The chapter outlines the structure of the thesis.

1.1 Background to the Study

The NP is a fairly new role in Australia, with the first NPs having been introduced in NSW in 2000 (Dunn et al 2010; Middleton et al. 2010). The NP is more experienced than a Registered Nurse and has completed additional education and training at an advanced level (Nursing and Midwifery Board of Australia 2010). The NP must have at least three years' full-time experience working in an advanced practice nursing role before applying to be authorised as an NP (Middleton et al. 2010; Nursing and Midwifery Board of Australia 2010). Applicants' qualifications are assessed and endorsed by the Nursing and Midwifery Board of Australia to allow them to function autonomously and collaboratively (Nursing and Midwifery Board of Australia 2010). The NPs are legally authorised to diagnose, treat, refer and prescribe specified medications in all Australian states and territories (Nursing and Midwifery Board of Australia 2010).

Nurse Practitioners were introduced into Australia for a variety of health care reform reasons aimed at reducing the pressure on the health care system's resources and funding (Williams et al. 2000). It was hoped NPs would address the health workforce shortage, "improve patient access to services, provide cost-effective care, target at-risk populations, provide outreach services in rural and remote communities and provide mentorship and clinical expertise to other health professionals" (Australian College of Nurse Practitioners 2014, para. 1). Even though NPs were legally recognised, many health care professionals and much of the Australian public had little understanding and knowledge of the NP role (Turner & Keyzer 2002), and hence the uptake of the NP role in Australia has been slow (Foster 2010).

Whilst the NP role has now been implemented in Australia for the previous fourteen years, the numbers of NPs in practice are small. According to the Nursing and Midwifery Board of Australia, in December 2012 there were 788 endorsed NPs in Australia (Nursing and Midwifery Board of Australia 2013b). These numbers are still low and significantly low when compared with the 229 153 practising Registered Nurses in Australia in 2012 (Nursing and Midwifery Board of Australia 2013b). This case study describes two NPs in rural Australia and adds to the

literature on NPs in Australia. It builds on the work of prominent authors, whose work has documented:

- The historical events leading to the development of the NP role in Australia (Foster 2010; Gardner & Gardner 2005)
- The development of the NP role in NSW (Foster 2010; Gardner et al. 2006; Turner & Keyzer 2002)
- The resistance to and difficulties involved in establishing NP roles (Foster 2010; Turner et al. 2007; Lauder et al. 2003; Mills et al. 2010; Osmond 2008; Taylor 2007; Turner & Keyzer 2002)
- Key events in the early development of the role, including the authorisation process (Foster 2010; Gardner et al. 2004; Gardner & Gardner 2005)
- The demography, profile, scope of practice and barriers to practice by NPs in Australia (Bail et al. 2009; Foster 2010; Gardner & Gardner 2005; Middleton et al. 2010; Middleton et al. 2011)
- The work schedule, prescribing practice and patterns of NPs in Australia (Dunn et al. 2010; Gardner et al. 2010b; Wilson et al. 2005)
- The NP competency standards (Gardner & Gardner 2005; Gardner et al. 2006)
- A range of instruments for researching NP service and clinical outcomes [AUSPRAC NP Research Toolkit] (Gardner et al. 2009)
- The core role of NPs (Arbon et al. 2008; Carryer et al. 2007; Dunn et al. 2010)
- Clients' understanding of the role of NPs (Allnutt et al. 2010).

The Australian Nurse Practitioner Project (AUSPRAC) was created in order to monitor the implementation of nurse practitioners into the Australian health service environment (Gardner et al. 2010a), and provided the first national census and information on Australian NPs, including the profile, process and outcomes of NP services in Australia. At the time of the first national census in July 2007, there were only 234 authorised NPs in Australia, and 202 of these responded to the census (Middleton et al. 2011). Of these, 117 NPs worked in metropolitan areas (Middleton et al. 2011). Only 5 NPs were recorded as working in primary health or community settings across Australia (Middleton et al. 2011). This census was repeated in 2009 and showed an increase from 5 to 12 NPs working in primary health or community settings across Australia (Middleton et al. 2011).

Research in Australia and overseas has confirmed that NPs are safe and competent and provide high-quality health care that is economical and valued (Allnutt et al. 2010). However, much of this research is focussed on NPs' providing care in acute settings in larger metropolitan and rural areas. For example, the work of Chen et al. (2009), Conlon (2010), Denniss and Fear

(2010), Elsom et al. (2005), Jennings et al. (2008), Mulvihill et al. (2010), Wand and White (2007), and Wilson and Shifaza (2008) all illustrate the value of NPs in acute settings such as emergency departments, paediatric units and acute mental health facilities. Absent from the literature are in-depth studies describing the NP roles in rural primary health care settings. This lack of description or evidence of effect makes the NP role particularly vulnerable to governments, health care boards, senior executive management and health care policy-makers and planners who may not see its value.

This study describes the role that has evolved for NPs in two rural primary health care settings within Northern NSW. It aims to provide an-in depth and detailed description of what these NPs are achieving within these settings and in relation to rural health outcomes at local, state and national levels. For the purposes of this study, primary health care is defined as *"the frontline of Australia's health care system"* (Commonwealth of Australia 2013, p. 6). It is

"…first level care provided by health services and systems with a suitably trained workforce … Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation" (Australian Primary Health Care Research Institute 2013).

According to a recent report published by the Commonwealth of Australia in 2013, primary health care *"can be provided in the home or in community-based settings such as in general practices, other private practices, community health, local government, and non-government service settings"* (Commonwealth of Australia 2013, p. 6).

1.2 Purpose of the Study

This research adds to the body of knowledge about NPs' practice by extending knowledge of this to primary health care delivered in a rural area of NSW. The research describes how and why these positions were established, and the perspectives of the role from the point of view of key stakeholders. This in-depth detail description of such NPs is not found elsewhere in the Australian literature.

1.3 Method Summary

A case study design enabled a detailed and contemporary investigation and analysis of two rurally located, primary health focussed NP services and their contexts. The study used multiple sources of data including documentary evidence, qualitative interviews and observation. In

investigating and interpreting the data, I aimed to develop an “insider’s” view of the NP’s role within these settings, including how key stakeholders understood and interpreted the NP role.

Case study methodology enabled the development of a detailed description of how the two NP-led services worked. This is particularly valuable when descriptions of roles like these are absent from the literature.

1.4 Research Questions

The study explores the impact of NP positions from the perspective of key stakeholders who were critical to the establishment and ongoing integration of these positions within the health service. It also investigates why these NP positions were established and aims to identify the key features that are unique to establishing these NP positions within a primary health care setting. The factors that contribute to the successful or unsuccessful delivery of the services provided by NPs are identified, as are barriers to implementing and continuing these NP services. The range of organisational characteristics that are needed to support these NP services is also explored.

The research questions can be summarised as:

- How and why were these NP positions established?
- What do these NPs do and how do they do it?
- What do stakeholders perceive as contributing to the successful delivery of the service?
- What organisational characteristics are needed to support such an NP service?
- From the stakeholders' points of view, are there any barriers to implementing an NP role in these settings, and what are the barriers to ensuring the ongoing success of the service?
- What is the impact of the NP positions from the perspective of key stakeholders who were critical to the establishment and ongoing implementation of these positions?
- What, if any, is the impact that NP roles are having locally, and at state and national levels?

1.5 Why I am doing this study

In a previous role I was a senior nurse directly involved in the establishment of several NP positions in rural NSW. I had firsthand experience of processes required to implement these roles, as well as the barriers and resistance that occurred as we tried to do this. I therefore have a strong interest in researching the NP role to examine how the roles have been working and what impact they have had, particularly in the small rural towns where NPs work.

In my role as a researcher for this study, I had to leave behind any preconceived ideas or assumptions I had about the NP role. This allowed me to construct and validate a description of how the NP roles have developed and to determine if the roles are accepted and are sustainable in the NPs' rural communities.

When I dealt with the NPs and the key stakeholders, I tried to be as unobtrusive as possible to allow me to report their descriptions of the NP service through their eyes. My experience and knowledge allowed me to modify the questions asked during the interviews to obtain a deeper understanding. It was useful to hear the perspectives of the medical staff now that the NPs have had nearly a decade to settle into their roles, as well as to hear from the senior managers who were proactive in getting these positions into place.

It is clear from my past experience before commencing this research that I already had my own beliefs, assumptions and perceptions about the NP role, and I needed to acknowledge that these would have some impact on the enquiry. However, I also felt my past experiences and perceptions would enhance the research. By drawing on my personal experience, I was able to make links between and interpret my experience of the implementation of the NP role, the literature on the implementation of NPs, and actual practice. Whilst I have provided a detailed description of two NP roles within rural primary health care settings, I have worked hard and reflexively to allow the NPs and key stakeholders to speak for themselves.

1.6 Organisation of the Thesis

Chapter 2 describes case study methodology and why this design was chosen for this research. It also discusses how the data were collected, ethical considerations and how the data were analysed.

Chapters 3 and 4 detail the two case studies, describing how the participants were chosen for each case study, how data were collected, the findings and , include a discussion of the implications of the findings for the practice, and practice setting, of each NP. Both chapters draw on evidence from the interviews and documentary evidence. Case Study 1 (Chapter 3) also contains quantitative data. In addition, Case Study 2 (Chapter 4) also draws on direct observational evidence.

Chapter 5 synthesises the findings from both studies with the literature. It draws lessons from the study of NPs in rural Australia who practise in primary health care settings.

Chapter 6 draws together key findings from the study and includes recommendations for future research.

1.7 Conclusion

This chapter provides an outline of the purpose and importance of the research, the background of the research and study design, and locates the researcher and her own background in relation to the study.

Chapter 2. Methodology and Methods

> *"Case studies help to confirm for others that they are not alone in their struggles and that others share their experiences, struggles, conflicts and dilemmas"* (Hayes 2006).

This research used a case study methodology to describe two NPs within their own arguably unique primary health care settings.

2.1 Case Study Methodology

Case study research endeavours to deeply understand the context of a phenomenon (Cavaye 1996). Using case studies encourages a focus on contemporary as opposed to historical phenomena (Yin 2009). It is the preferred method when "how" or "why" questions are being posed, when the investigator has little control over the event and when the focus is on a real-life context (Baxter & Jack 2008; Swanborn 2010; Yin 2009).

Case study research uses a variety of data sources and excels at providing an understanding of a complex issue or an object. It can extend experience or add strength to what is already known through previous research (Baxter & Jack 2008; Swanborn 2010).

Case studies have been used for many years by researchers across a variety of disciplines. Social scientists, in particular, have made wide use of this qualitative research method to examine contemporary real-life situations and provide the basis for the application of ideas and extension of methods. For example, Taylor et al. (2013) used the case study method to understand the role of community health sector partnerships for primary prevention. Sangster-Gormley (2013) also used a case study method to explain the process of the NP role implementation in three primary health care settings in British Columbia and to identify factors that could enhance the implementation process.

Whilst there are many different ideas about the nature of a case study, there is agreement that case study should have a "case" which is the object of study. The "case" should be a complex functioning unit, which, for example, may include a large variety of factors and relationships.

In this study, case study methodology facilitated the researcher in understanding the nature and complexity of the NP roles as expressed in their practice and context and in determining how and why these positions were established.

Using case study methodology was particularly effective as it allowed the NP services to be described from the stakeholders' perspectives in the context of the small rural towns. The study gave a contemporaneous, 'insider's view' of how these positions were established in an unusual setting, how the NP positions actually worked, and what this has meant for the local communities.

The use of case study methodology facilitated in-depth examination of a considerable range of data collected about the two NPs and the services they ran (Richards & Morse 2013). The data collected were rich and detailed (Richards & Morse 2013). The case study methodology included opportunities for observation (visiting some of the small rural towns and sites where the NPs provided services), leading to further and richer insights. Being able to observe the surroundings, the NPs' practice locations, distances from larger regional hospitals, and people's behaviour in relating to the NP added to the description of the NPs and their practices.

Use of case study methodology provided a systematic and well-known technique to investigate and interpret how both NP roles worked. It used insiders' views and focuses on how key stakeholders within the setting understood or interpreted the NP role. These case studies are broadly based; for example, Case Study 2 also investigates how an NP can provide leadership at state and national levels, as well as locally.

2.2 Selection of the Cases

Each of the NPs was purposefully selected as participants to help meet the aims of the research in delineating how NPs work in primary health care settings. The two NPs worked in different specialties and had very different scopes of practice. In addition, both had held their positions for sufficient time to allow the researcher to collect enough evidence to describe their roles, as these had evolved over time. Both of the NPs were female, reflecting the demographic data regarding nurses in Australia, where 89% are reported by the National Nursing and Midwifery Board of Australia registration data as female (Nursing and Midwifery Board of Australia 2014). The location of the NPs was chosen pragmatically. They were geographically close to the researcher, minimising time and travel costs. Two cases were selected to maximise the research outcomes in the period of time allocated to this research to permit in-depth study. There are limitations to this pragmatic choice, however, as both NPs are located in the same Local Health District.

The study is defined by the location and focus of the study; that is, the primary health care setting in mental health in a small rural town, and aged care across a number of small rural towns and settings within a Local Health District. The selection of the NPs for this study was

targeted to capture different roles, the duration of these roles, and how effective they were clinically or in demonstrating professional leadership.

Case studies provide good sources of ideas about behaviour within cases, and the method gives rise to opportunities to describe an innovative program. There are, inevitably, challenges inherent in case study methodology. It is difficult to draw definite cause-effect conclusions, it is hard to generalise from a single case (or in this study, two cases), and inbuilt biases may be present when a single person gathers and analyses the data.

2.3 Ethical Considerations

Both case studies received low-risk ethics approval from the Local Health District Human Research Ethics Committee. This ethics approval was endorsed by the University of Sydney. A participant information sheet was provided for each participant, explaining the purpose of the study, why they had been invited to participate, how participant information would be kept confidential, and who to contact if they had any questions or concerns about the study (See Appendix 1). Written consent was obtained from all participants. Only the researcher and supervisors had access to the transcripts, which were de-identified after transcription. A formal confidentiality agreement was made with the transcription service, stating that copies of the interviews, in all formats, would be destroyed within 30 days after acknowledgement of the receipt of the transcribed documents, and that transcribing staff would only have access to the audio-recordings for the purposes of transcribing. The transcribing service was located interstate, thus adding to the protection of the identity and confidentiality of the participants. Both the transcripts and audio-recordings were held on a password-protected data base. Throughout the study, the National Health and Medical Research Council ethical guidelines were followed, and all files from the study will be kept in a separate locked cabinet for 5 years. Because both of the NPs came from small rural towns, extra care has been taken in writing this thesis and in planned publications, to preserve the anonymity of the NPs as well as the other participants. This was ensured through the de-identifying of NPs and key stakeholders in all transcripts, as well as removing the names of the small rural towns and/or hospitals in which they worked.

2.4 Data Collection and Analysis

There were three methods of qualitative data collection: interviews, documentary analysis and observation. For Case Study 1, quantitative evidence also formed part of the case study.

2.5 Individual Interviews

Interviews for Case Study 1 were conducted by the researcher and others in the wider research team, and by the researcher only with all participants in Case Study 2. The study used semi-structured interviews with open-ended questions (Yin 2003) to elicit the participants' opinions and experiences of the NP service. An interview topic guide was used for each interview, setting out the key topics and issues to be discussed (Ritchie & Lewis 2003). The questions were different across both case studies to enable the research to focus on the particular features of the role and each NP's practice.

Further details about the interviews, how the interview participants were chosen and copies of the interview guides are provided in each of the case studies (See Chapters 3 and 4) and in Appendices 2–5.

2.6 Interview Transcription

All interviews and meetings were digitally recorded and transcribed with permission from the participants. One was transcribed by the researcher, the others by a professional transcription service. The digital audio-recordings were transcribed into Microsoft Word documents and checked for accuracy by the researcher.

The interviews were transcribed using true *verbatim* transcription, which captured not just the words but all verbal communication on the recordings, such as laughter or pauses. This provided attention to detail and in particular highlighted that *how* something was said was equally important as *what* was being said. There was no editing of the transcripts by the transcribers, and everything was typed out just as it was on the recording. All of the interviews were listened to in order to confirm the accuracy of the transcripts. This process also helped to immerse the researcher in the data and to identify themes that were starting to emerge, as well as identify any inconsistencies. This was important to the process of data collection, verifying the transcription and beginning the analyses.

2.7 Collection and Analysis of Documentary Evidence

A range of documentary evidence was used for each case study. These documents were sourced from the NP as well as participants in each case study. Whilst the documents were not coded they were read and re-read by the researcher within the context of other data and

discussed with the participants and/or the study supervisor/s. This process deepened understanding and contributed to validation of other information gathered for the case study.

For Case Study 1, unpublished documents were collected from 2004 to 2011. These included a formalised Partnership Agreement, annual Progress Reports, the NP Scope of Practice (a formal document/agreement), briefing and discussion papers, and Minutes from meetings. A list of these documents is located in Chapter 3 – Case Study 1 (Table 3.6).

The documentary evidence for Case Study 2 included the NP Standards for Practice, NP Scope of Practice and Minutes from local and state-wide committees meeting. A list of these documents is located in Chapter 4 – Case Study 2 (Table 4.3).

2.8 Observation

Observations took place during this study in a relatively casual way. On several occasions the researcher visited the workplaces and the small towns where the NPs worked, as part of the interview and data gathering process. This type of observation is described by Yin (2003) as a direct observation, where the researcher makes a field visit to the case study site. These observations were recorded in a field note diary to ensure reliability of recall.

Swanborn (2010) also describes observation as complementary to a case study and describes how observing surroundings and people's behaviour can provide further insight into the case. This type of observation can be carried out during a field visit or when interviewing participants (Swanborn 2010).

Observation of direct interactions with clients was not undertaken in Case Study 1 in order to respect the sensitivity regarding mental health clients and because ethical approval to include clients of the service in the study had not been sought. The NP in Case Study 2 was observed in two separate formal settings. Both of the settings were committee meetings. The first was at a state level and the second at a local level. An observation protocol adopted from Creswell (2012) was developed and used to focus the observation in both of these settings in Case Study 2 (see Appendix 4.2). The data from the observations were used to provide further evidence to describe the NP's leadership role in Case Study 2. It is possible that the presence of an observer/researcher may have had some impact in terms of changing behaviours of either the NP or her colleagues and influencing what the researcher saw, how people behaved and therefore the results. It did help that the researcher was very familiar with the setting and that she was a nurse herself.

2.9 Credibility of the Data

Case studies are likely to be much more convincing and accurate if they are based on several different sources of information and employ single or multiple methods of data collection (Baxter & Jack 2008; Yin 2009).Using more than one method strengthens the reliability and validity of the study (Baxter & Jack 2008; Yin 2009). Yin (2009) listed up to six sources of data that can be used in a case study protocol; however, not all need to be used in every case study (Yin 2009). Case Study 1 used interviews, a stakeholder meeting, documents and quantitative evidence, whereas Case Study 2 also added more formal observation. The strengths and weaknesses of each type of data collection are listed in Table 2.1(Yin 2003).

Table 2.1: Strengths and weaknesses of different types of data used in case study methodology. Adapted from Yin (2003, p. 86)

Source of evidence	Strengths	Weaknesses
Documentation	Extensive reporting of issues over a time span, including Minutes of meetings, reports and policies Stable – repeated review The ability to collect unobtrusive data that existed prior to the case study	Biased selectivity Not always easy to access
Interviews	Targeted and insightful Focused on the actual case study topic	Can be biased due to poor questions Response bias Reflexivity – interviewee may express what interviewer wants to hear
Observation	Authenticity – covers events in real time within their contexts	Time-consuming

		Selectivity –may miss facts Reflexivity –observer's presence may cause changes in behaviour

One difficulty with undertaking research with multiple data sources is the large volume of information collected (Balbach 1999). By the time observations are completed, interviews conducted and documents analysed, it can be difficult to write a concise summary of findings (Balbach 1999). These difficulties were managed by the use of careful notes taken after each interview and observation, noting things that were unusual or required follow-up. Information was well-managed and carefully filed. Credibility of the data was also strengthened by going back to the NPs in each of the case studies to verify and validate findings throughout the study.

2.10 Triangulation of the Data

One major feature of case study methodology is that different sources of data are combined, with the purpose of illuminating a "case" from different angles. This "triangulates" or verifies analysis and conclusions by combining sources of data (Yin 2009). The use of triangulation helps to confirm and improve the validity of qualitative research, and can be utilised when using both qualitative and quantitative methods to compile data about the same research question. This was described by Ritchie and Lewis 2012 as "methods triangulation" and occurred in Case Study 1. Also in Case Study 1 and Case Study 2, triangulation of the sources of data, including perceptions of key stakeholders and documentary evidence, was used. Case Study 2 included observations. By using these multiple data collection methods, validity was strengthened (Ritchie & Lewis 2012).

2.11 Thematic Analysis

Thematic analysis (Braun & Clarke 2006) was used to analyse the data from interviews for each case study (and for Case Study 1 from the stakeholder meeting). A rich thematic description of the entire data set was developed by following a number of steps. In phase 1 of the analysis the accuracy of the transcriptions of interview recordings was checked and any necessary corrections made. All interview transcripts and field notes, as well as the documentary evidence, were read through repeatedly in order for the researcher to become familiar with the overall data set and the "fit" of data collected in various ways. This initial analysis identified any gaps in the available evidence and the need for further interviews or documents to be collected. During this phase of initial reading, analytic notes were kept to record initial impressions, to identify and note key points, to consider how each data source reinforced, extended or challenged previous sources, and to look for and record connections. New ideas were explored to describe what each NP does, and to note anything that was interesting and important.

The qualitative data analysis program, *NVivo 10,* was used to help organise and keep track of the data. During phase 2 of the analysis codes that were initially identified from the research questions, as well as from the literature, were used to label the data initially. These were then grouped into broad categories. Based on these broad meaningful groups, the data from the interviews were coded systematically. Observing diverse opinions among participants was also important for providing an accurate description of the service.

Examples of the categories created for each case study include:

- A description of the service
- A description of the community
- Principles underlying the development of the service
- Why the service was established.

Phase 3 of the analysis was based on searching for themes that connected or explained categories. This step involved looking at the relationships among the categories, comparing differences and variations in the data, and moving beyond the categories to establish themes. The most significant part of the analysis involved describing how the themes fitted together and creating an overall narrative about the data. Comparing differences across what different participants said and looking for patterns were essential. The findings were also compared with the literature. This is discussed in the results section for each case study.

In summary, data were reduced and analysed by means of codes, categories and themes in a process derived from Braun and Clarke (2006). Themes gradually emerged as a result of knowing the data well and making associations with the interview questions. The initial review of the literature, as well as frequent discussions and confirmation from the research team, were helpful. At successive stages, themes moved from a “low level of abstraction” or description to become more interpretive; however, the study is more descriptive than analytic.

2.12 Summary of Chapter 2

This chapter has described the methodological and practical aspects of this study and how they were applied. The next chapter focuses on Case Study 1.

Chapter 3. Case Study 1: A Nurse Practitioner Led Mental Health Service in Rural Australia

3.1 Introduction

This case study describes the conception, development and operation of an NP led, rural, community-based mental health (MH) and drug and alcohol (D&A) related service in a small rural town in NSW. The case study describes and reflects upon how a rural primary healthcare based NP works in practice, the small rural town where the NP is located, the characteristics of the clients of the service, and how and why the NP service was developed. It also explains the aims and activities of the service and details what the NP actually does. The case study reviews the impact this service is having on the small rural town and the barriers faced in the implementation and ongoing operation of the service.

The case study was chosen pragmatically, as part of it was from the researcher's work-related opportunity to undertake a formal evaluation of this NP service. The case study uses two sets of data: the formal evaluation that included permission from the outset to be used as part of a postgraduate research study; and a further literature review as well as further analysis of the documentary and interview data and further discussion with the NP about the findings for the case study, that was subsequently conducted for the purposes of this research.

3.2 Background to Case Study 1

Primary health care is defined as the part of the health system that people use most; it is the first point of health care delivered to people outside the hospital setting (Commonwealth of Australia 2013). Primary health care services can be delivered in a range of settings and under numerous funding arrangements (Commonwealth of Australia 2013).

The NP led service described in this case study fits well with this definition, as the service is located at the heart of the community in a well-used and multi-functional, non-government (and non-health) organisation. It provides support for a large number of people with MH and D & A related problems. The NP described in this study not only provides acute care to clients in a mental health and/or drug and alcohol related crisis, but is able to provide longer-term management of these clients in partnership with a range of other services. This type of service is unusual in a small rural town, as typically MH and D&A related services are either not available, or are provided at a more specialised, acute-care level by visiting specialists.

3.3 Mental Illness in Australia

Mental illness is a significant complex problem and the largest cause of disability in Australia (Australian Government Department of Health and Ageing 2010a). Thirty-two per cent of the population will experience mental illness at some stage in their lives, and when alcohol and drug disorders are included, this rises to forty-five per cent(Australian Government Department of Health and Ageing 2011). If services are not available to prevent mental illness, or detect it early so that treatment and support can be provided, disadvantages such as poor health, social isolation, discrimination, homelessness, unemployment, poverty and tragedy such as suicide frequently result (Australian Government Department of Health and Ageing 2011). The Australian Institute of Health and Welfare estimates that six billion dollars is spent on MH related services per year (Australian Institute of Health and Welfare 2012). Over the last ten years, Australian federal and state governments have been increasing their investment in MH, particularly in the primary health care setting.

Despite some successes, the MH system remains crisis-driven, with many people only receiving help when they are at their most vulnerable, instead of receiving help to stay well (Australian Government Department of Health and Ageing 2011b), and services are often fragmented (Allan 2010; Bambling et al. 2007; Buchan & Boldy 2004; Cleary et al. 2009; Hodgins et al. 2007; Veysey et al. 2005). This creates gaps, prevents people receiving the full range of services that could provide optimal paths to recovery, and potentially results in avoidable mental health crises(Australian Government Department of Health and Ageing 2011b).

3.4 Literature on Rural Mental Health Services in Australia

Both academic studies and grey literature were included in the literature review for Case Study 1. Grey literature included government reports that focussed on service models of health care in rural areas, with a particular emphasis on MH and/or D&A. Only Australian literature was included, to ensure a comprehensive review of relevant Australian rural mental health services.

The initial search for academic studies was carried out in October 2011 using the MEDLINE, Informit, Psyc INFO and EBM databases. These databases were selected as their content is multidisciplinary and covers a very broad range of health topics. The literature was examined to answer the question: *What models of publicly funded mental health services exist in rural areas of Australia?* The search terms are outlined in Table 3.1. Figure 3.1 outlines the stages of the literature search.

Table 3.1: Literature review MeSH Terms (Medical Subject Headings)

MeSH terms	Limits applied
• alcohol* • area* • Australia • care* • country • deliver* • delivery of health care, integrated • drug* • framework* • health • health services accessibility • healthcare • hospitals, rural • integrat* • mental • mental disorders • mental health • mental health services • mental* • model* • outback • regional • remote* • rural • rural health • rural health services • rural population • service* • system	• Humans only • English language • All adult • Last ten years • Australia

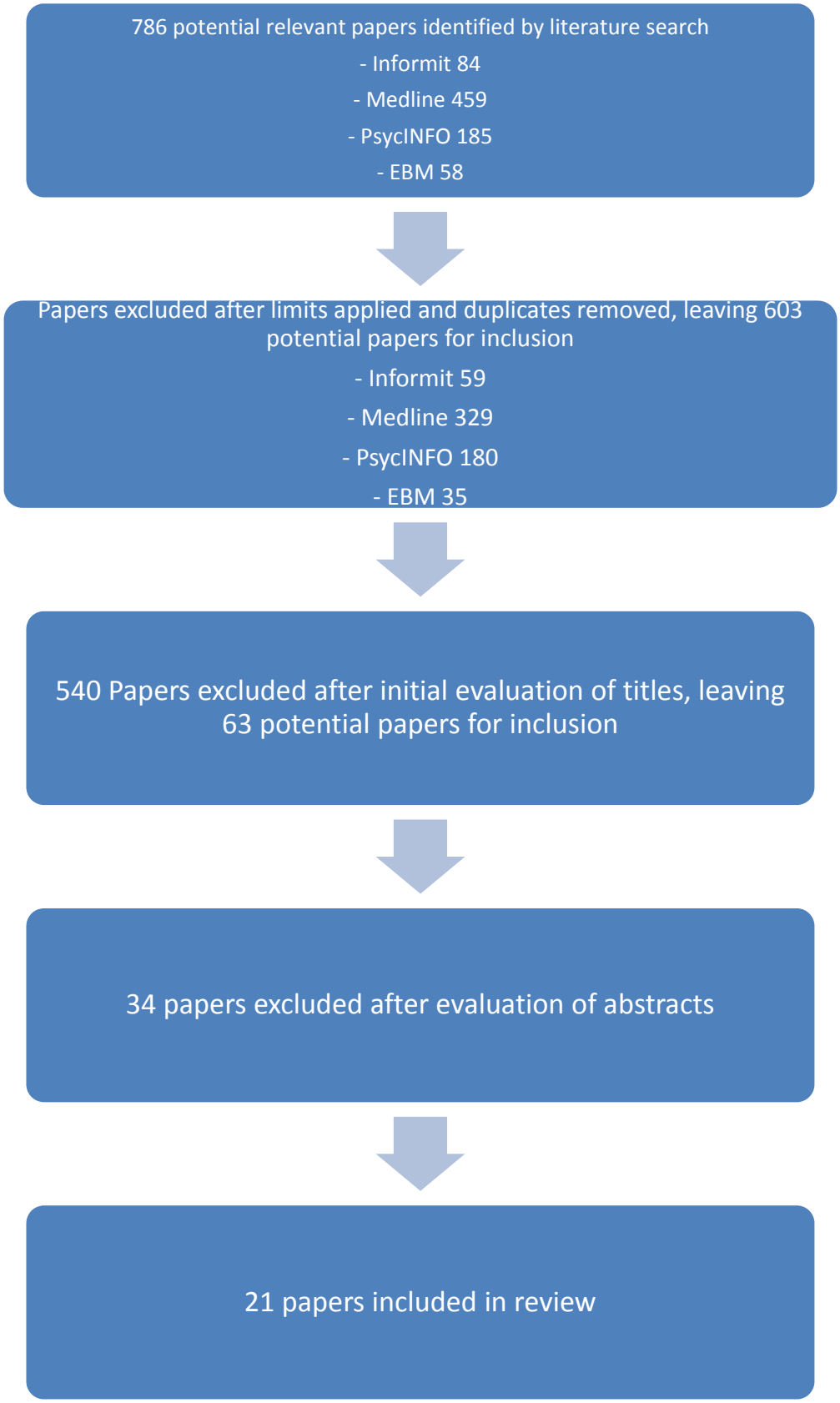

Figure 3.1. Flowchart of literature search stages

Over 700 papers were identified from the initial search strategy. Inclusion criteria included refereed or peer-reviewed academic journals, English language, Australian studies, human studies only, and papers published in the last 10 years. Papers published about youth, infants and children were also excluded. Literature more than ten years old was not included, due to the significant changes to health service structure, management, and policy, regulatory and legislative frameworks that have occurred in the last decade.

The majority (540) of these 700 papers were excluded after removing duplicates and reviewing the titles of each paper for relevance to Australian rural mental health services for adult patients. The abstracts of the remaining papers were then examined for relevance to rural mental health services. For all studies that met the inclusion criteria, or in cases where the title and abstract were inconclusive, full texts were retrieved and assessed for relevance. This left a total of 21 papers for inclusion in the final literature review for this case study.

It is interesting to note that of these 21 papers, there was no work that described services in detail, and none that described NPs in Australian rural mental health services for adult patients. No papers offered a reflection on how the NP role could be integrated in mental health services in small rural communities.

A further search focussing on grey literature was conducted in February 2012. Australian Government reports were sourced from the Australian Department of Health and Ageing website, using mental health as a subject heading. These were also examined. A summary of the reports and programs identified that relate to this research is provided in Table 3.2.

Table 3.2: Reports and Programs

Report/Program	Year
National Mental Health Strategy [as reviewed in Department of Health and Ageing (2010)]	1st plan1992 – 1997 2nd plan 1998 – 2003 3rd plan 2003 – 2008 4th plan – 2009
Australian Integrated Mental Health Initiative (Nagel 2006)	2003 – 2006
National Mental Health Report 2010: Summary of 15 Years of reform in Australia's Mental Health Services under the National Mental Health Strategy 1993 (Department of Health and Ageing 2010)	2010
National Standards for Mental Health Services (Australian Government Department of Health and Ageing 2010b)	2010
Council of Australian Governments National Action Plan for Mental Health 2006-2011 Fourth Progress Report covering implementation to 2009-10 (Council of Australian Governments 2012a)	2006 – 2011
National Mental Health Reform (Roxon et al. 2011)	2011
The *Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS* (Better Access) initiative (Pirkis et al. 2011)	2011
Mental health service in rural and remote areas program evaluation Final Evaluation Report (Australian Government Department of Health and Ageing 2011)	2011
NSW State Plan 2021 (Department of Premier and Cabinet 2011)	2012
Roadmap for National Mental Health Reform 2012 – 2022 (Council of Australian Governments 2012b)	2012

The published literature on mental health services in rural Australia supports the reports from the Australian Government Department of Health and Ageing (2011b) regarding gaps in

services, resulting in avoidable mental health crises. A number of studies highlighted the fragmentation of services and in particular a lack of integration in the provision of MH services in rural areas (Allan 2010; Bambling et al. 2007; Buchan & Boldy 2004; Cleary et al. 2009; Hodgins et al. 2007).The studies confirmed that providing MH services to small rural communities is often centred on crisis management and relies heavily on visiting mental health specialists providing care on a sporadic basis (Bambling et al. 2007). This situation exacerbates difficulties specialist MH and/or D & A clinicians have in being able to build trust and rapport with patients and their families, and in establishing and maintaining effective links among service providers (Anderson et al. 2011).These difficulties are further compounded by staff shortages in rural areas (Cheyne-Macpherson 2007; Morrissey et al. 2007). In addition, research focussing on professionals in primary healthcare settings shows that in practice they often lack experience and understanding of intersectorial links, leading to significant gaps in inter-service communication, referrals and liaison between service providers (Bambling et al. 2007). There are limited examples in the literature of Health and/or D & A services that provide ongoing support for clients in the community (Allan 2010; Bambling et al. 2007; Buchan & Boldy 2004; Cleary et al. 2009; Hodgins et al. 2007).

Mental health services in the public health sector are funded by state or territory health departments. Non-government organisations also provide services, which may be funded from either source. The types of MH services available in rural Australia, while limited, do include residential and community services, hospital-based services, and hospital-based outpatient services, as well as care provided by MH specialists and general practitioners (Australian Institute of Health and Welfare 2012).

There are significant difficulties for consumers and carers in accessing MH care in rural areas. Contradictory approaches to treatment by different providers create difficulties and result in fragmented services that are often complex for rural consumers and carers to negotiate (Eagar et al. 2005). Additionally, inconsistent sources of funding create difficulties (Eagar et al. 2005). Small rural towns often lack hospitals, and as funds for MH care are often focussed on acute services only, access is usually limited to crisis situations, or consumers are required to travel to their nearest regional centres (Humphreys & Wakerman 2008). There is also a shortage of adequately trained MH and D & A workers employed outside acute mental health facilities to provide appropriate and accessible services for clients with a dual diagnosis (i.e. those who experience both mental health and substance abuse difficulties) (Victorian Government Department of Human Services 2007). This workforce shortage problem is compounded by lack of educational opportunities, facilities, and ongoing support in rural areas for MH and D&A workers to care for these dual diagnosis clients (Substance Abuse and Mental Health Services Administration (US) 1998). In addition, MH and D&A workers in rural areas may come from

different organisations, jurisdictions or governance structures and provide separate services. As a result, these workers may not communicate with each other or any other members of the primary health care team. In some cases, clients with a dual diagnosis may be discriminated against and treated as though they are less worthy of help than others (National Mental Health Commission 2013).

Along with increased investment in mental health, a commitment to integration of mental health services was a prominent feature of Australian National Mental Health policy, as described in the documents listed in Table 3.2. Integration was intended to ensure greater collaboration among providers, better continuity of care and improved capacity for early intervention. Although integration was described in several major mental health policies (See Table 3.2), it was difficult to find evidence in the literature of this actually occurring in practice.

Kodner and Spreeuwenberg (2002) highlight the importance of integration of services when dealing with chronic and complex patients, such as MH and D&A patients, who are vulnerable and who have complicated and ongoing needs. These needs include medical, physical, psychological and social needs. Mental health patients require regular services in the community to manage and prevent crisis situations, as well as services to provide ongoing care and support (Australian Government Department of Health and Ageing 2011b). Without the integration of services, patients often fall between the cracks of primary and acute care. Services are also likely to fail to be delivered or are delayed, quality of care and patient satisfaction decline, and the potential for cost-effectiveness diminishes (Kodner & Spreeuwenberg 2002).

Kodner and Spreeuwenberg (2002, p.3) give a definition of integration, which best describes this study of care delivered across multiple services, providers and settings:

> *"…a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration, within and between the cure and care sectors."*

To some extent, the NP described in this study facilitates an integrated, community-based MH and D & A related service in a rural town. Examples of how this is achieved are highlighted throughout this chapter.

To summarise, the literature shows that rural clients requiring MH and/or D&A services are severely disadvantaged compared with their city-dwelling counterparts. Rural MH and D&A services are crisis-driven and fragmented, resulting in an increased number of avoidable mental health crises for rural clients. Lack of integration of services, combined with a workforce

shortage of MH and D&A workers, and possible discrimination against clients with dual diagnosis, only compounds this disadvantage. Whilst the Australian National Mental Health policy aimed to integrate services to resolve some of these issues, in practice little evidence of integration was found in the literature. However, a working definition of integration from Kodner and Spreeuwenberg (2002) does fit this case study.

3.5 Methods

As outlined in Chapter 2, this study used descriptive case study methodology and included multiple sources of evidence. Sources included documents, and qualitative data gathered from a group interview, a stakeholder meeting and 16 individual semi-structured interviews. Quantitative data were examined to establish the number of clients and referrals into and out of the service.

3.6 Qualitative Data Analysis: Group Interview, Individual Interviews and Stakeholder Meeting

3.6 (a) Participants interviewed

A combination of purposive and snowball sampling was used to identify key participants. Snowball sampling, according to Ritchie and Lewis (2012, p. 94), is "an approach that involves asking people who have already been interviewed to identify other people they know who fit the selection criteria." Sixteen participants were interviewed individually to elicit information and opinions about the NP service. An additional five participants took part in a group interview. Purposive sampling was based on the following criteria: (a) individuals or roles deemed essential to the establishment of the position by key stakeholders (including the NP herself); (b) key partners in the current operation of the service; and (c) leaders responsible for the establishment or management of the service. Participants included senior managerial staff from local health services, a local General Practitioner (GP), a police superintendent, nursing representatives from acute MH care or D & A services, and representatives from regional government and local non-government organisations (NGOs). Some of the participants had been involved in the development of the service over a number of years. They regularly attended community meetings, as well as interagency committee meetings, in response to a number of D & A related violent incidents in the town. Table 3.3 provides an overview of research participants and their employment locations. Please see Appendices 2 and 3 for the one-on-one interview guide and group interview guide respectively.

Table 3.3: Overview of research participants and employment locations (n=21)

Description	Location
Nurse Practitioner(n=1)	Local Health District
Senior Managers (n=4)	Local Health District
Regional Government Managers (n=2)	Senior government organisation
Nursing Leaders (n=2)	Local Health District
Manager, non-government organisation (n=1)	Non-government organisation
Mental health workers, drug and alcohol workers, community nurses and nurses from Emergency Department (n=7)	Local Health District
General Practitioner (n=1)	
Police Superintendent (n=1)	NSW Police Service
Representatives, community-based organisations (n=2)	Non-government organisation

Participants were initially contacted by email and then followed up with phone calls. Participants provided written consent to participate in the study (Participant Information Sheets and Participant Consent Forms can be found in Appendix 1). Once agreement was given, the participants were contacted by phone or email to set up mutually agreed times and locations for the interviews. Only one participant chose not to participate.

Half of the interviews were held at the participants' workplace in a quiet room, thus also providing an opportunity to observe the workplace. The other interviews were held in a quiet room in the author's workplace, for the convenience of the participants. The NP was interviewed on two separate occasions; this enabled further questions to be asked and evidence to be confirmed. Two participants were interviewed by phone. All interviews and meetings were audio-taped and transcribed with permission from the participants. Field notes were taken immediately after each interview to capture the mood and anything that was said that was unusual, and to make a summary of any important themes or ideas that would require further investigation. The interviews lasted between 30 and 60 minutes.

In addition to 16 individual interviews, a stakeholder meeting was held by teleconference to generate a shared narrative on the conception and birth of the service and to understand what stakeholders were aiming to achieve with the establishment of the service. The stakeholder meeting included three key stakeholders involved in the service from the outset, all of whom had also participated in individual interviews. The stakeholder meeting lasted for 45 minutes.

A face to face group interview was also conducted with 2 participants from the local hospital emergency department, 2 participants from the community nursing service, and 1 participant from a welfare agency, to gain a wider perspective of the service from those who were linked with the service. Similar questions were used to those above. The group interview lasted for 1 hour.

3.7 Documentary Evidence

A range of documentary evidence was collected to contribute to understanding the context of the service and to answer how and why the service was developed. Table 3.6outlines the documents reviewed.

Table 3.4: Documentary evidence

Year	Document examined
2004	• Review of current Community Service Program aimed at reducing mental health and drug and alcohol related violence
2005	• Briefing Note to Department of Health to secure funding for a community-based program to reduce mental health and drug and alcohol related violence • Government Agencies Meeting Minutes • Strategy Discussion Paper • Letter to stakeholders • Discussion paper circulated for discussion and consultation with members of the small town community • Community Issues Working Group Meeting Minutes • Community patrol meeting • Brief for local Cabinet meeting • Letter to stakeholders from the Director of the non-government organisation
2006	• Partnership Agreement • Working Group Minutes • Strategy: Integrated Health Care Worker • Interagency Meeting Minutes
2007	• Interagency Meeting Minutes
2008	• Interagency Meeting Minutes
2009	• Nurse Practitioner Scope of Practice document • Interagency Meeting Minutes
2008–2011	• First Annual Progress Report August 2008 • Second Annual Progress Report December 2009 • Third Annual Progress Report December 2010 • Fourth Annual Progress Report December 2011

3.8 Quantitative Evidence

Non-identifiable aggregated client data on referrals to and from the service, broad demographic data on clients, client throughput, and the number of contacts per client were collected from the NP's records and analysed descriptively. This enabled an understanding of client characteristics, flows through the service, and identification of other services linked to the NP service. Data were not directly collected from clients. However, some documentary evidence, including anonymous feedback from clients, and data collected from the Australian Nurse Practitioner Study (AUSPRAC), which had previously worked with clients of the service (Gardner et al. 2009), were available. The national AUSPRAC (Phase 2) study was conducted

throughout 2008–2009 and included direct feedback from a number of the NP's clients. Ethics approval was granted to use this feedback as part of the formal evaluation, and five transcripts were obtained.

3.9 Analysis

As described in Chapter 2, thematic analysis was used to produce a rich description of the entire qualitative data set.

Initial coding was grouped into categories which included:

- Description of the Nurse Practitioner service
- Why the service was established
- What the service does well
- What the service does not do well
- Aims and objectives of the service.

Themes established were:

- Integration of services
- Management and accountability
- Access to services
- Partnership.

Members of the research team (researcher and supervisors) read and discussed the documentary evidence, and a summary was generated, adding breadth and depth to the understanding of the case study. To ensure validity of data analysis, a supervisor coded one interview independently early in the process and any points of departure were explored at a subsequent supervisory meeting. It was found that the coding was very similar, ensuring that the validity of the data analysis was maintained.

A summary of the documentary evidence was compared with data gathered from other sources and also used to further refine the themes. Findings from the documentary evidence were also discussed with research participants, further integrating findings, identifying issues requiring further exploration in later data collection and providing some triangulation of data.

3.10 Findings

3.10 (a) A description of the small rural town and the characteristics of the services available before the Nurse Practitioner was introduced

At the time of the study, the small NSW rural town had a population of about 1500 people and was located 35km from a larger regional town. The service population was estimated to be between 3,000 and 5,000 people. The way MH services were offered in the town was very similar to many other small rural towns described in the literature, in particular where the MH services were described as being crisis-driven (Adesanya 2005; Australian Government Department of Health and Ageing2011b;Harvey & Fielding 2003),supplied by visiting specialists from a larger regional centre (Allan 2010) or service outreach programs (Harvey & Fielding, 2003; Perkins & Lyle 2005; Perkins et al. 2006), and fragmented(Allan 2010;Bambling et al. 2007;Buchan & Boldy 2004; Cleary et al. 2009;Hodgins et al. 2007;Veysey et al. 2005.)

Participants reported that because services were fragmented, crisis-driven or supplied by visiting specialists, patients and their families were unable to access any ongoing regular MH services. Similarly, they were unable to establish trust and rapport with a single clinician who could provide crisis and acute management, ongoing management and support or education and links to other services, as recommended in government policy and as observed in other studies (Anderson et al. 2011). Consistent with reports in the literature, combined MH and D & A services for clients with dual diagnoses were unavailable (Victorian Government Department of Human Services 2007). Clients were required to travel 35km to their nearest regional centre for this type of service (Humphreys &Wakerman 2008). There was no evidence of an integrated MH service.

The services that were available included:

- A multi-purpose centre which offered a combination of hospital and community health services, including 24/7 access to emergency services, a detoxification service (although participants reported that this service was used infrequently) and a Methadone service six mornings a week.
- Community mental health services, available one day a week. Clinicians at the multipurpose service were also able to access a 24-hour MH Access Line to Acute Care Service and Extended Care Service at the regional town.
- Drug and Alcohol counselling services were provided one day a week by community services at the multi-purpose centre.

Participants described the population as highly transient and socio-economically deprived. They also stated that the population members were, in general, accepting and tolerant of diversity and social issues. It was reported that the town had an unusually high frequency of drug and alcohol use, mental health problems, violence, crime and homelessness. Based on this description of the town and its population, mental illness was a significant and complex problem. It was compounded by the high frequency of drug and alcohol use, unemployment, poverty and homelessness, all significant risk factors outlined in Australian government policy (Australian Government Department of Health and Ageing 2011b).

3.10 (b) Summary of the service

Initial coding of participants' responses were grouped into the following categories which described the service:

- Why the Nurse Practitioner service was established
- How the model was established
- Description and activities of the Nurse Practitioner led service.

Further analysis produced these themes:

- Impact of the service
- Provision of an integrated service
- Barriers to implementing and ensuring ongoing success of the Nurse Practitioner led service.

3.10 (c) Why the Nurse Practitioner service was established –participants' perspectives and documentary evidence

Both participants' reports and documentary evidence confirmed that the NP led service was established in response to community concerns about the amount of violence and anti-social incidents occurring in the small rural town. These incidents were often highly visible in the street and, according to the participants, had a significant MH dimension. Health services provided were limited, fractured, from "outreach" programs and usually reactive in nature. This led to an overall lack of response to the issues, including a lack of Local Health Service presence, absence of continuity of care and lack of preventative focus in the care that was provided. There were apparent service gaps, particularly for dual diagnosis clients. There were also concerns about services not working well together. The NP led MH service was built on a foundation of community concern and considerable effort over many years by the community itself.

"…it wasn't just about the town getting trashed…there was a compassion issue for us in that because these matters all were generally ending up in the hands of the police…a lot of them largely had health issues or substance abuse issues rather than criminality issues. And that it was the lack of service provision that was driving them into these states of mind or whatever that would, you know, push them over the edge and then they would act out in the middle of the street. And then the next thing they'd be wrestled into a paddy wagon by the police in front of the whole town, which was traumatic because lots of people knew those people and, you know, you'd have people trying to rescue them from the police and all this just general pandemonium going on because people felt a degree of compassion towards these people. And didn't necessarily want to see them manhandled into the back of paddy wagons and from the point of view of the police…didn't want to be in the position where their main role in the town was manhandling people with mental health or substance abuse issues that were having psychotic incidents into the back of paddy wagons and cart them off to hospital and then stand around the clinic for hours waiting for them to get admitted. So… it was also about the management of those people and a sense of there must be a better way to deal with these people that's more compassionate." (Manager, non-government organisation)

Participants also consistently reported that clients with MH and/or D&A problems were reluctant to use the hospital or any formal health or government service due to a combination of factors, including dislike of authority, the stigma of having an MH problem, fear of being institutionalised due to an MH problem and concern about criminalisation of their D&A behaviour. They found that clients saw the hospital an "alien" and "hostile" environment, and had a general dislike of western medicine approaches. Some of this is illustrated in the quote below:

"They're either paranoid because they've got mental health issues or they're paranoid of being further criminalised or telling anyone in case they get the cops on them if they're drug and alcohol users or drug users or illicit drug users. And they're paranoid about being wrestled away into institutions…but for this client group that's what their fear is and that's what their family's fear is of too." (Manager, non-government organisation)

3.10 (d) How the model was established– participants' reports

A Steering Committee was formed in 2004 to provide a solution to the community's concerns described above. The committee consisted of a representative from the local Police Service, Local Health Service representation, including representatives from senior management, Drug and Alcohol services, Mental Health and Acute Care Service (ACS), a manager from the MPS Service, Probation and Parole, NSW Community Services, and the Department of Education and Training. This group was responsible for establishing if and how a new service would work to

address the community's concerns, the type of service to be provided, how the service would be funded, the location of the service, and how it would be maintained. It was also a role of the committee to gain the support of the community in establishing such a service.

In 2006, a formal Partnership Agreement was developed. Signatories to the agreement included representatives from the NSW Regional Co-ordination Program, Local Area Health Service, a local NGO, Department of Community Services and signatories from the NSW Police. Having senior managers from several agencies supporting the establishment of the service was described as essential to integration, as well as ensuring this new service model would work. Senior management involvement was seen as key to the implementation of the Partnership Agreement. The documentary evidence showed that the Agreement defined roles and responsibilities and put in place mechanisms to ensure performance and accountability. The objectives of the service were outlined in the Partnership Agreement 2006. These were:

- To provide an effective and efficient human services delivery model that addresses the health, social and welfare needs of the community
- To work collaboratively to ensure the sustainable and equitable delivery of human services to the community
- To employ a full-time Integrated Health Care Worker
- To provide triage, assessment and short-term case management of people wanting health and welfare related assistance
- To provide access to other services such as Mental Health, Drug and Alcohol and community services and allow for referrals to be made and followed up by tertiary services
- To share information between agencies and the community regarding service planning, monitoring, evaluation and reporting
- To ensure sustainable funding, management and maintenance of the service
- To improve the integration of services offered by each agency.

The Partnership Agreement provided for useful additional features of integration, including sharing staff among pre-existing services, engaging multi-skilled staff who embraced change and coexistence, coordinated meetings to discuss service provision, and case review.

The literature suggests that effective integrated services enhance communication among staff members and services that would not otherwise have had much contact (Anderson et al. 2011). Other benefits of inter-sectoral collaboration discussed in the literature include removing service access barriers, improving effectiveness, removing duplication, and driving integrated, coordinated and flexible solutions for the local community (Anderson et al. 2011;Bambling et al.

2007;Barnes&Rudge 2003;Cleary et al. 2009;Hodgins et al. 2007;Judd et al. 2004; Perkins et al. 2006). The literature further suggests that the management of integrated services is improved by frequent meetings for the stakeholders of each of the programs and sites including management, and meetings with all service providers. This is achieved in this setting through the interagency meetings as well as the Partnership Agreement. The literature also suggests the implementation of consistent policies and procedures across all services, including referral processes, and education programs to ensure that all staff and services are aware of how the service works (Anderson et al. 2011; Bambling et 2007; Barnes et al. 2003; Cleary et al. 2009; Hodgins et al. 2007; Judd et al. 2004, Perkins et al. 2006). The Partnership Agreement and the leading of the new service achieved many, but not all of the above provisions in this setting. For example, there were not consistent policies and referral processes across all of the services, and not all participants were aware of how the service worked.

The Steering Committee members were *in situ* before, during, and after the NP was appointed in 2007. Thus, they were able to provide valuable perspectives and insights during the research into how the NP led service was implemented and how this service contributed to addressing the community's concerns. Initially, the position of practitioner for the service was advertised as a full-time integrated Health Care Worker. It had not been identified or even considered that an NP could fill the role. An NP was appointed to the position as she was the most suitable applicant in the recruitment process. Subsequent to the appointment, the effect of having an NP in the role was seen by many, although not all, as particularly beneficial, and most participants understood and welcomed the NP role. For example, the initial objectives for the service changed once the capacity of the NP was realised. The NP was able to provide more than just triage and assessment of clients; she could oversee longer-term management of these clients, in partnership with a range of other services. The NP took on a leadership role in helping the Steering Committee, as well as other key partners, understand the NP role, which developed over time. The development of clear guidelines and expectations, as well as a reporting framework, helped the committee understand the NP role and to clarify how the role would work. These processes were regularly discussed at the Steering Committee meetings. It is interesting to note that at the time that this NP led service was established, the role of the NP in Australia was very new and its potential was generally not fully understood.

The service was established using Local Health Service owned MH funding. Interviews show this was not universally welcomed by all health professionals working in MH locally. In part, this appears to be based on MH funds being redirected from overstretched acute services and a perceived lack of integration with MH services and systems within the model. There were reported tensions with some of the MH services from the larger regional town and the NP service because the funds to establish and maintain this position were taken from their acute

service funding. Also, this was because the appointment of the NP was seen as being "outside the system" and its usual hierarchy and accountabilities. This tension across services is consistent with the barriers to effective integration described in the literature as an absence of clear service models, deficiencies in organisational culture, and an absence of integrated education, such as between the acute mental health team and the NP (Allan 2010; Anderson et al. 2011;Bambling et al. 2007; Barnes et al. 2003; Bartels et al. 2004; Cleary et al. 2009; Eager et al. 2005; Hodgins et al. 2007; Judd et al. 2004; Perkins et al. 2000; Vesey et al. 2005).

3.10 (e) Description and activities of the Nurse Practitioner led service

The NP service was established in June 2007. It consisted of one full-time NP specialising in MH as well as D&A services. Participants initially expressed a very broad range of ambitious aims for the NP service including:

- Overcoming the barriers between agencies
- Improving the amount, type and level of mental health services available to the small town
- Addressing service gaps, particularly regarding dual diagnosis clients
- Diffusing crisis situations in collaboration with the police and other service providers
- Reducing the level of violence and anti-social behaviour in the town
- Providing treatment to clients to prevent escalation into crisis
- Integrating preventative approaches
- Proving education and health promotion
- Establishing rapport and trust within the community.

The service also aimed to be proactive rather than purely reactive, endeavouring to prevent escalation of particular situations, generally related to mental ill health and D&A misuse/dependence.

The NP was permanently based in a well-used, multi-functional non-health community organisation in the centre of town. The Steering Committee agreed the location on the basis of its central location, and that it was in a "neutral" and "safe" (i.e. non-medical) NGO, rather than a hospital/MPS service.

The NGO operated as a one-stop-shop with an "open-door" or the latterly developed "drop-in" model of service delivery. The NGO provided generalist welfare services, including information and referrals, support and counselling, emergency relief vouchers, food and meals, soup kitchen, and vacation care. It also provided access to facilities such as computers, phones, faxes and photocopiers. The NGO also accommodated outreach service providers, such as job service

providers, Probation and Parole and Legal Aid, and was an outlet agency for Centrelink. It was reported that the majority of service clients who accessed the NGO were disadvantaged people, including financially struggling families with children, people experiencing violence (family and domestic violence), people with mental well-being issues and people with drug and alcohol issues.

Participants reported that the NP worked through close street-based contact across the small rural town, seeing a wide range of clients, 20% of whom the NP classified as *in crisis*. Flexible, immediate, short- and longer-term support was offered to clients with a range of mental health problems, including those with dual diagnosis. The service offered immediate crisis management and support, as well as early intervention and ongoing maintenance. A 3–6 months average client engagement with the NP was reflected in the quantitative data from the service. The frequency of client contact with the NP service ranged from 1 to 16 times, with each appointment lasting from 0.5 to 4 hours. The total hours per patient spent by the NP ranged from 0.5 to 17.5 hours, and averaged 5.69 hours.

The NP led service was predicated on integration of the NP into the local community. Consequently, some of the NP's work was described as "street-based", as opposed to functioning in a hospital or General Practice setting with clients on an appointment-only basis. For example, due to the location of the service, the NP described actually being able to *hear* when an issue was developing on the street, and thus being able to immediately intervene.

> *"…has an enormous impact on the number of mental health interventions the police need to become involved in. This is a very desirable outcome for both police and the client in that for the most part police do not have the level of expertise that [the NP] is able to call upon when intervening or assessing a mental health incident…Having the option of calling [the NP] …is an invaluable resource that should not be underestimated in the difficult policing environment that is found in [the town]..."* (Police feedback reported in Annual Report 2009-10).

In addition to "street-based" work, the NP also received referrals from the GP, the emergency department of the local hospital, the Police Service, community nurses, clients' friends and families, needle and syringe programs and Women's Health services. One-third of clients were self-referred. The vast majority of clients were adults. The NP referred clients to a wide variety of services, including Youth and Family services, carer respite, Immigration, Centrelink, D & A services, the local GP, dieticians, the nearby regional hospital, dental services, Women's Health services, and acute MH services. The NP offered peer support, education and training, and generally coordinated MH services for the small town. The NP also provided a promotion and prevention service and was actively involved in community events promoting mental health

and well-being, e.g. a town health promotions event for Mental Health Week. The NP also arranged rehabilitation for clients when required.

Participants reported that the NP was well-supported and trusted by the local GP and senior management, as well as all members of the Steering Committee and the wider community. This trust and acceptance resulted from her extensive level of experience, skill and knowledge related to dealing with clients with MH and D & A problems.

From the description of the activities provided by the NP led service, it can be seen that the service offered many examples of effective integrated care, as described in the literature. This included care provided in the community, communication and referrals among service providers, the reduction of stigma and acute care medical expenditure, the avoidance of artificial separation of medical and psychiatric problems resulting in substandard care, and access to timely treatment (Perkins et al. 2006; Veysey et al. 2005).

3.10 (f) Impact of the service

Participants described the accessibility of the NP service, and linked its accessibility to its location, flexible delivery and integration of MH and D & A services. The personal qualities of the NP and her contribution to lessening the stigma of mental illness were particularly mentioned. The participants also reported positive flow-on effects from the NP led service to other health and social services in the community, and a reduction of emergency mental health-related hospital admissions.

> *"So by and large they go, go and see [the NP]. So the fact that [the NP] just has a continuous stream of new clients, even though the whole town knows exactly what [the NP] does and is well aware of it, is an achievement in itself"* (Manager, non-government agency).

Many participants reported that the *location* of the service was a key factor in its success. The non-government organisation was reported as being a "safe" place and more relaxed than the hospital or GP surgery. Its centrality in the town contributed to improved access for clients, as well as the "street-based" work of the NP described above. The NGO also offered a degree of anonymity as there were a myriad of reasons to visit the community service. This also contributed to reducing the stigma of MH problems and opened access to clients seeking MH support in the small town. This stigma may account for why people were reluctant previously to use MH services located in the hospital.

> *"…somebody sees them walking into [the organisation] off the street, nobody would think anything of it."* (Manager, non-government agency)

> *"The ability to consult with the NP in a relaxed environment makes it easier to attend appointments. Mine is an ongoing malady and access to mental health through the Non-Government Organisation is made easier by the location and not a hospital environment."* (Mental Health consumer)

> *"… [The NP] does more of an outreach, because [the NP]'s based down at the community centre, there are people that see her much earlier than they would have seen us."* (General Practitioner)

The NP led service also had positive ramifications for other services in the small town. Several participants used the phrase, "take the pressure off", to describe the benefits to their staff of the active NP position in the community. These included the Police Service, the hospital, the GP practice, the D&A service and the NGO.

> *"So [the NP] took a large load off our work, of our mental health work." (*Mental Health Nurse)

Staff also reported benefiting from the expertise of the NP in advising and guiding their own practices. A local GP provided feedback that the NP accurately and appropriately prescribed, and that they trusted the NP's expertise in prescribing medications for mental health and D & A patients. Other staff described that the NP "models" how best to handle mental health and/or D&A crises and behaviours, not only for other professionals but also for the public in the street.

Participants reported that the NP led service was successful because the NP had a connection to the community. The NP was perceived as caring about the mental health and well-being of the community. The presence of an NP was an important contributor to the success and connectedness of the service.

> *"…having the person …working, in this case [the NP], working there Monday to Friday in the street, visible, seen. They [the community, including clients] know. And that connectedness is really important…"* (Manager, non-government agency)

The NP described in this setting was very senior and experienced and chose to live within the community. Feedback from a consumer survey administered to 20 clients by the NP in 2009–2010 included the following, as reported in the Annual Report for 2009–2010:

> *"It feels great to finally find a practitioner who 'gets it'. [The NP's] experience and professionalism shines through. I would strongly support the NP service, it has helped me and it should remain to help others."* (Mental Health consumer)

> *"The NP is a wonderful service and much needed. Very easy to access and very useful. The NP is very approachable and helped me enormously." (Mental Health consumer)*

> *"This NP service has made enormous difference in our lives and most probably 'Life Saving'. Thank you!"* (Mental Health consumer)

All respondents to this consumer survey reported feeling safe and confident using an NP and would recommend the service to others. The NP was unanimously described positively by these mental health consumers. Comments included:

> *"[The NP] is very well-known and well respected in the community."* (Mental Health consumer)

> *"... [The NP] has fitted incredibly well into the community."* (Mental Health consumer)

> *"… [The NP] was a very good fit, I think, for that job. And [the NP] had a personality that was good for it." (Mental Health consumer)*

> *"It takes a special person to do it."* (Mental Health consumer)

The consumer survey was administered to only 20 clients, invited to complete a survey by the NP, and this may have resulted in bias due to the NP's selection of the respondents. The above quotes illustrate consumers' positive response to the NP service. However, some of the clients who had a negative experience with the NP service may not have been willing to record this in writing.

It is possible to speculate from population-based data that the NP led service had made a contribution to reducing MH hospital emergency department presentations and to reducing drug-related offences in the small rural town. In 2006, before the NP service was implemented, 152 mental health, assault and drug and alcohol patients were admitted to the small hospital Emergency Department (ED). The Nurse Practitioner was employed in June 2007 and admissions dropped to 30 in 2009.

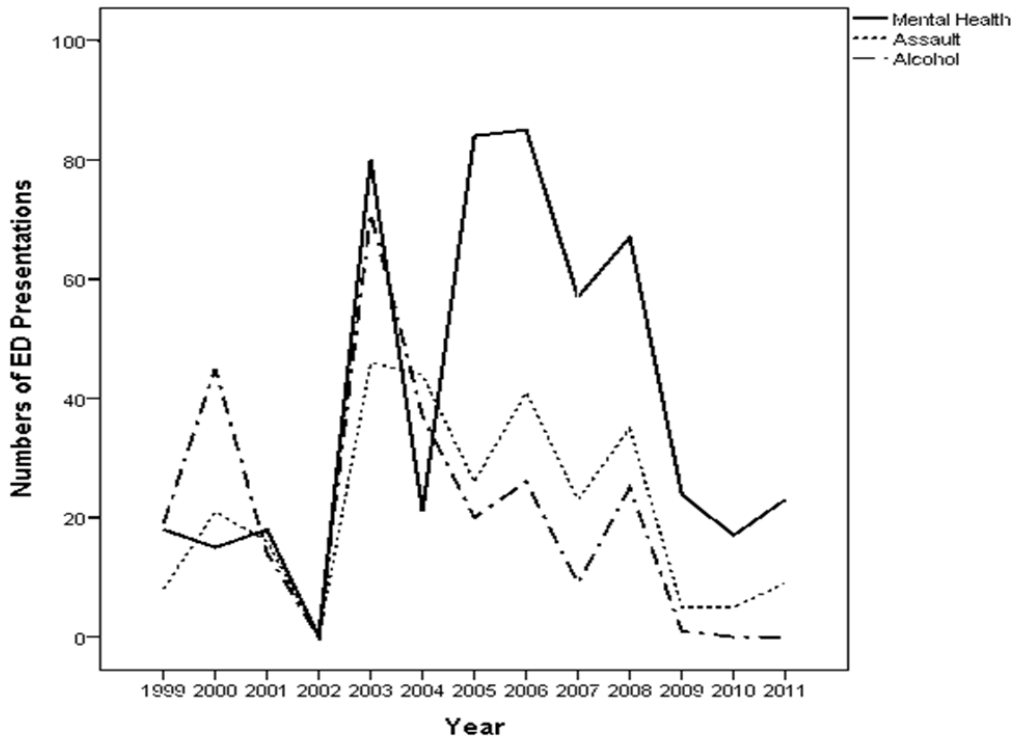

Figure 3.2: Emergency Department presentations from the local hospital 1999–2011

It is worth noting that because residents of this small town are highly transient, the before and after data may well be affected by this. For example, 2006 may have been a year with elevated numbers of MH-related ED presentations and hospital admissions, whilst 2009 may have had fewer MD-related ED presentations for reasons other than the introduction of the NP service. The lower MH-related ED presentations and hospital admissions in 2009 were statistically significant but may actually reflect specific features of the 2009 residential group, features that were not evident in the 2006 population, rather than the success of the NP service. Therefore, the descriptive evidence gathered across a range of participants has been of more importance in this case study.

The qualitative data also supported the premise that the NP had made a significant difference in reducing street-based violence. Participants commonly reported there had been a reduction in violence in the town:

> *"…there is less violence than there ever was…"* (Manager, on-government agency)

Participants suggested the NP service contributed to achieving the aims of Goal 11 of the NSW State Plan 2021, which includes prioritising early intervention in the community for mental

health clients, moving treatment away from the hospital and the emergency department, and ensuring that people with mental illness are diverted from the criminal justice system where possible (Department of Premier and Cabinet 2011).

3.10 (g) Provision of an integrated service

The establishment of the NP led service resulted in the *integration* of MH and D&A services.

> *"Drug and alcohol and mental health operated very differently, one would go out and see clients in their own home, and the other service would not. People would fail to come to appointments. They couldn't bring the two cultures together, everybody knew that."* (Nursing Leader)

> *"Most of the people had a dual diagnosis and mental health would say we can't see them they've got a drug and alcohol problem."* (Nursing Leader)

Evidence of integration in the current operation of the service was described by participants in terms of clients having ongoing access to the service, and the ability to access a range of other services:

> *"…the liaison role of the NP makes it easier for clients to access other services."* (General Practitioner)

The service was also reported to facilitate quicker access to specialist MH services than had previously been possible.

Participants described little connection between agencies prior to the establishment of the NP service and limited examples of collaboration across health and other community and welfare services, such as probation and parole, Community Services, Youth and Family services, the hospital, the police and General Practice or D&A services. For example, barriers between the D & A, MH and general health services and the police were frequently described:

> *"We had this…disconnectedness between service provisions."* (Nursing Leader)

Participants reported that prior to the establishment of the NP service there was poor integration between the hospital and local welfare services. For example:

> *"Health has always been very insular and we have never looked at the non-government bodies and exactly what they can do and how they can help us."* (Nursing Leader)

The NP service demonstrated integration between partners at a client and worker level, particularly between the NP and other services within the NGO:

> *"…the Brighter Futures worker, [the NP] and our welfare workers… some of our clients are shared between them. So if they're a Brighter Futures client they'll be on the Brighter Futures case load … but at the same time that client we might have our welfare workers sorting out an issue for them like a local housing thing and we might also have [the NP] working specifically around a mental health issue."* (Manager, on-government agency)

Integration between the hospital and the NGO and between the NP and the police was also evident:

> *"…we sort of work with the cops and the cops come down and the handover's done between [the NP] and the police."* (Manager, non-government agency)

Examples of integration between the NP and the D&A in-patient clinic at the larger regional centre were also given. For example, participants reported that the NP received notification when a client was discharged from the clinic in the regional centre.

This NP provided an integrated service that was consistent with many of the recommendations from the policy documents in Table 3.2, i.e. a service that was based on a model of care developed specifically for the needs of a local community. The NP service was implemented with considerable input from a broad range of services, including state, regional and local government and non-government organisations. It formalised connectivity and collaboration among these and other services. Most importantly, the NP service established an accessible service and ongoing support to patients and their families in a small rural community. The NP service is an example of an integrated service and contrasts with the "siloed" services antithetical to effective care in D & A and MH areas (Allan 2010; Bambling et al. 2007;Buchan & Boldy 2004; Cleary et al. 2009;Hodgins et al. 2007; Veysey et al. 2005).

At the leadership and management levels, the existence of integration was evident from signatories to the Partnership Agreement and membership of the Steering Committee. This kind of collaboration provides advantages to each agency in terms of the ways they do business and do business together, what keeps the partners/services together (their shared vision and motivation), and the benefits of a multi-agency approach to problem-solving (Anderson et al. 2011; Eager et al. 2005).

Whilst there was clearly some collaboration between the NP and MH services at the larger regional hospital, it is possible that both services may benefit from the existing integration and collaboration being strengthened by, for example, MH inviting the NP to case conference meetings when shared clients are being discussed, the NP using systems of recording and referral which fit MH systems, and MH involving the NP in discharge processes for shared clients.

3.10 (h) Barriers to implementing and ensuring ongoing success of the Nurse Practitioner led service

The service was established without funds for administrative or reception support for the NP and without funds for clinical supervision. Participants reported that the service would benefit from these issues being addressed. They also reported a lack of clarity regarding the target client group for the service, resulting in the NP being put in a vulnerable position, by being required to respond to demands from all kinds of clients from a wide catchment.

No robust formalised contingency plans for any absence of the NP were in place at the time of the case study. This can be seen as another potential barrier to the ongoing success of the service; in some ways, the NP service is in danger of being a victim of its own success.

> *"As a sole practitioner the NP may be particularly vulnerable to burn-out."* (Senior Nurse Manager)

Other barriers to ensuring the ongoing success of the service included limited opportunities for referring clients to other services, in particular, rehabilitative services, and difficulties about transporting clients. Some participants drew attention to difficulties with incompatibilities of systems of referral, or the need to record client data by both the NP service and MH services, leading to duplication of effort. In addition, participants reported communication issues and a lack of formal recognition in the wider MH services of the contribution that the NP makes to seeing clients in the service. Some participants expressed a sense of lost opportunity that the most senior MH nurse in the area (the NP) was not an integrated part of the MH team. All opportunities for shared learning, support and mentoring were not therefore being realised.

One participant made the point that the service might benefit from funding from all the partners:

> *"…my worry is that it then becomes fully funded by mental health services when in fact it's a shared responsibility and it always was meant to be between community health, drug and alcohol, mental health, the hospital system and enhancement from the health*

service. So health was going to look at a multifaceted approach to it, and again the shared approach to how do you look after that level of population in that town through a multi-pronged approach. And I think it's become a singular funded, singular entity health approach. And I think that's moved from the model a long way. So to me that's the disappointment in the model." (Senior Manager, Local Health District)

In terms of the wider applicability of this model of integrated MH care to other rural settings, several participants made recommendations which are also consistent with the literature. These recommendations include:

- Existence of senior management change-makers across organisations to champion the idea. This point is also made in studies by Bartels et al. (2004), Eager et al. (2005) and Vesey et al. (2005).
- Development of local systems to enable governments, non-government organisations, providers and the private sector to do business with each other and the community to remove service access barriers, improve effectiveness and remove duplication (Anderson et al. 2011; Eager et al. 2005)
- Establishment of a clear understanding of what and where the service will target
- Collaborative development and regular review of the Partnership Agreement
- Clear referral processes and agreed referral protocols
- Careful consideration of the *funding* of the model, including
    - administration/secretarial/reception support for the Nurse Practitioner
    - shared responsibility for funding across agencies rather than funding from a single agency
- Appropriate formal clinical supervision(either with a psychiatrist or another experienced Nurse Practitioner)
- Protected non-client time for the Nurse Practitioner to attend and participate in meetings, professional development and supervision
- Time for "corridor conversations" to maximise integration; or if there is no co-location, then there must be time for people to get to know each other. Clinicians are more likely to refer to one another and take referrals if they know other clinicians. This can be facilitated by measures such as joint supervision and ongoing professional development across clinicians.
- Direct line management of the Nurse Practitioner to be a "neutral" overseer role, i.e. a manager who is able to work across and understand the language and approach of each of the partners

- Co-location of the Nurse Practitioner with as many partners as possible to enhance referrals and communication among providers and collaboration in treatment planning (Bartels et al. 2004)
- Opportunities for the placement of undergraduate students in medicine, nursing and allied health to work with the Nurse Practitioner to improve their skills and knowledge of working in a primary health care setting and within an effective integrated rural mental health model.

3.11 Discussion

This case study demonstrates the relevance and importance of having an NP working in a primary health care setting, and in particular the effectiveness of an NP led MH and D & A related service in a small rural town. The study also contributes to the literature on NPs in rural primary health care settings, as well as describing how integration works within this setting. The NP mental health service was regarded by most participants as a viable solution to address the D & A and MH needs of a high-needs community. The service is an exceptional example of an integrated service and contrasts significantly with the "siloed" services adverse to effective care for D&A and MH clients. The NP took on a case management role for clients with the cooperation and collaboration of a number of different government and non-government agencies.

The NP was able to provide crisis management as well as ongoing treatment and support, to help clients maintain their overall health. This study demonstrates that integration is challenging to achieve in a health service context which is usually hierarchically organised and accountable. The study highlights the complexity of implementing an NP role at a practice level and systems and organisational levels, and the need to have key stakeholders, including community members, government and non-government agencies and other services, involved early in the implementation of the position. The study also demonstrates that the best location for an NP led service may not necessarily be a public hospital setting. This study has confirmed that an NP led model of integrated care is successful for treating and managing clients with MH and/or D&A problems. The study highlighted the substantial challenges to integration of a rural NP led MH service.

The case study described the NP service and the level and nature of the integration of the service, within the context of rural MH service policy in Australia and the literature on integrated MH services. This service is an illustration of most of the key elements of integration, as outlined by Kodner and Spreeuwenberg (2002). The service was established and maintained by formal collaboration among number of government and non-government agencies, supported by a Steering Committee and a Partnership Agreement. There was evidence of inter-

agency planning of the service and working together to ensure its ongoing success. There was several years' lead in-time, with these agencies working together before the service was established. The physical integration of the service (co-located with an NGO) was seen to contribute to the success of the service.

The model became a "one stop shop" where the NP service acted as a front door to other services and developed into a model within a community-based, non-medical, non-mental health agency with numerous other service providers. Once the NP was put in place, the service was ongoing and client-centred to fit the needs of this particular client group.

There were some study design limitations. Interview data from patients and members of the public were not gathered directly. Whilst this may have been ethically and practically difficult, it could potentially have added to the richness of the case study. However, patient data from annual reports, as well as quantitative data gathered as part of the evaluation, helped to describe patients' interactions with the NP service. We also had permission from Professor Glen Gardner and her team from Queensland University of Technology to use client data from their AUSPRAC study. Further detailed descriptions of how other NP services function in small rural communities would greatly enhance future development and implementation of the Nurse Practitioner role.

Chapter 4. Case Study 2: The Nurse Practitioner as a Leader in Primary Health Care

4.1 Introduction: Aims, Objectives and Research Questions

The goal of the second case study was to describe in detail the role of another Nurse Practitioner (NP) who also worked in a rural environment across a range of primary health care settings. The NP featured in this case study provided a psychogeriatric specialist service to a broad geographical area and across a variety of services, including small rural hospitals, community health centres, residential aged care facilities and a larger regional hospital. The NP provided direct clinical care to older patients with a complex diagnosis of dementia and/or delirium. She also provided a visible leadership role, a critical element of the NP role as outlined in the *Nurse practitioner standards for practice* (Nursing and Midwifery Board of Australia 2014b).Her leadership influenced how care was provided to older people at local, state and national levels and across a range of rural primary health care settings. This case study shows the potential for NPs to contribute to and influence how rural primary health care is provided locally, regionally and nationally.

The objectives of this case study were to provide a description of this Nurse Practitioner service including:

- How and why the Nurse Practitioner service was developed
- What roles (including leadership), tasks and duties the Nurse Practitioner performed
- Stakeholders' perspectives of how the Nurse Practitioner service actually worked.

The main research questions examined in Case Study 2 were different from Case Study 1 in that they focussed on providing evidence of the NP functioning as a leader in the primary health care setting. Evidence was collected from local, state and national levels. The research questions were:

- What evidence exists to describe the leadership function of a Nurse Practitioner in a rural primary health care setting?
- What evidence exists describing the leadership influence the Nurse Practitioner has on policy or practice at local, state and national levels?

The purpose of Case Study 2 was therefore to describe and reflect upon the influence of an NP in a primary health care setting, focussing on the potential of an NP to contribute to rural health care through leadership, not only in the immediate clinical environment but through leadership in the wider context of rural health service delivery.

4.2 Setting the Scene for the Case Study

The NP led service described in this case study fits with a definition of primary health care as being:

> "*Health care delivered in the community, outside of hospitals in a range of service context." (Australian Institute of Health and Welfare 2014, p.82)*

The NP had the ability and scope to operate across a broad range of services and geographical locations, coordinating the care of older, complex clients in an NP led outpatient clinic, residential aged care facilities, small rural hospitals, a multipurpose centre and a larger regional hospital.

4.3 Literature

In Australia, leadership is recognised as a major part of the NP role. The *Nurse practitioner standards for practice* were revised in 2014(Nursing and Midwifery Board of Australia 2014b). These standards endorse leadership in the clinical setting, as well as community and political engagement for NPs. As part of this policy, leadership is described across four standards: 1) assessment, 2) planning care and engaging others, 3) prescribing and implementing therapeutic interventions and 4) evaluating outcomes to improve practice. Nurse Practitioners are expected to practise within these standards as part of the Health Practitioner Regulation National Law (Nursing and Midwifery Board of Australia 2014b). As part of standard 4, NPs are expected to provide evidence of advocating for, participating in, or leading systems that support safe care, partnership and professional growth (Nursing and Midwifery Board of Australia 2014b).

Despite leadership being endorsed as part of the legislation for NPs in Australia, there are very few published papers describing exactly how NPs are providing leadership in rural areas, and what impact this has for small rural communities. A CINAHL search focussing on NP leadership in rural and/or primary health care, using the search terms, subject headings and keywords (Table 4.1) produced only eight papers on advanced nursing leadership in rural primary healthcare settings relevant to this study. Papers that were too specialised or focussed on other settings were excluded. Two Australian papers by Carryer et al. (2007) and Watson (2008) that specifically described the leadership role of NPs in rural and/or primary health care settings were found.

Table 4.1: Search terms, subject headings and keywords used in the CINAHL search

Search terms and keywords
• Nurse Practitioner • Advanced nursing • Advanced Nursing Practice • Primary care • Primary Health Care • Rural health • TI (leader*) OR AB (leader*) • TI (advocat*) OR AB (advocat*) • TI (educator*) OR AB (educator*) • TI (mentor*) OR AB (mentor*) • TI (integrat*) OR AB (integra*t) • Nursing leaders • Health Educators • Health Care Delivery Integrated

In Carryer et al.'s (2007) paper, clinical leadership is recognised as one of the three core roles of the NP, along with dynamic practice and professional efficacy. Carryer et al. (2007, p. 1819) describe leadership in this context as a *"…readiness and an obligation to advocate for their client base as well as their profession at the systems level of health care."* This description looks beyond leadership in clinical practice to include the profession and the "systems" level of health care. This definition fits with the aims and objectives of this study. Although leadership was described by the authors, they acknowledged that they were unable to provide examples of how and whether this is occurring in practice, due to the newness of the NP role. This study can begin to fill the gap. Watson (2008) argued that the degree of leadership skills and attributes demonstrated by different NPs varies considerably and again reinforces that more research is required in this area. Watson's (2008) paper focussed on assessing nurses for their leadership ability at the time of applying to become an NP.

Other recent papers described leadership in the context of advanced nursing roles that were not specific to NPs, but were relevant to rural settings. Leadership was highlighted as important in the rural context in three areas: 1) to mentor and support other nurses, 2) to develop a culture that supports nursing, and 3) to be a clinical teacher and advocate for other rural nurses (Conger & Plager 2008; Humbert et al. 2007; Mackay2007; Sullivan-Bentz et al. 2010). Other important aspects of leadership in the rural context were the ability to share knowledge and

experience about the local community and having a connection to the community (Conger & Plager 2008; Humbert et al. 2007; Mills et al.2009; Sullivan-Bentz et al. 2010).

For the purposes of this research, and to build on the definition from Carryer et al. (2007) and Watson (2008) to establish a framework for leadership in the rural context, a very early paper by Flahalt and Roemer (1986), *Leadership for Primary Health Care,* was useful. This paper, published by the World Health Organization, provided the most comprehensive description of the characteristics of leadership specific to the primary health care setting. It identified behaviours and characteristics that show leadership in the primary health care setting and provide an avenue to describe or measure these types of behaviours, including:

- Enthusiasm for the concept of primary health care
- Self-discipline to enable reacting with others positively as a leader
- Courage
- Ability to cope with opposition
- Willingness to take initiative and introduce new ideas
- Perseverance
- Flexibility and willingness to change plans and procedures as required
- Integrity.

Flahalt and Roemer (1986) argue that leadership in a primary health care setting should be based upon sound knowledge, experience, enthusiasm, initiative and integrity. The leader must inspire the members of the primary health care team to do their work with energy and dedication. If the primary health care leader is effective, his or her responsibilities for leadership should become lighter as time passes and the primary health care workers gain experience (Flahalt & Roemer 1986). Similarly, Garrubba et al.'s (2011) literature review on clinical leadership produced parallel themes that were relevant both to this research, and to the nursing profession. These themes were (Garrubba et al. 2011, pp. 4–6):

- Influencing peers to act and enable clinical performance
- Providing peers with support and motivation
- Playing a role in enacting organisational strategic direction
- Challenging processes
- Driving and implementing the vision of delivering safety in health care
- Seeking to improve on current practice and using their influence to achieve this.

The literature review revealed a dearth of literature exploring NPs and leadership in relation to primary health care and rural areas. However, the papers found did help formulate a

framework that described leadership relevant to NPs in the primary health care setting. The framework was used to formulate the definition of leadership used in this study. Ideas in the papers also contributed to the development of initial codes for the thematic analysis undertaken for this study.

Leadership in this study is defined, therefore, as a readiness and an obligation to advocate for clients as well as the nursing profession at the systems level of health care. Advocating for, participating in, or leading systems that support safe care, partnership and professional growth are all essential components of leadership in this study. In order to do this, NPs must be innovative and enthusiastic, show initiative and integrity, and have advanced knowledge and experience in her/his field. Leadership is also shown by the NP in the ways she/he influences, supports and motivates peers, and influences others to collaborate, to reform and improve current practice, to challenge processes and to drive and implement consumer-focussed health care. The NP must be willing to take initiative and to introduce new ideas, and be willing and have the courage to cope with opposition.

4.4 Methods

As in Case Study 1, a descriptive case study methodology was applied, using multiple sources of evidence gathered specifically for this study. The evidence included documentary evidence and observing the NP in two settings to observe leadership in practice. Qualitative data were gathered from ten individual semi-structured interviews. The study received ethical approval from the Local Health Service's Human Research Ethics Committee. Local site governance approval was also obtained (See Appendix 1).

4.5 Participants Interviewed

A combination of purposive and snowball sampling was used to identify potential participants to interview. This provided a diverse sampling of interviewees across the range of rural, primary health care services. Sampling was based on the following criteria: (a) individuals or roles deemed essential to the establishment and current management of the position; (b) key stakeholders who worked with the NP in the current operation of the service at a local level and across a variety of settings including primary health care; and (c) key stakeholders who worked with the NP in the current operation of the service at a state or national level.

Ten participants were interviewed to gain an understanding of this NP role, including how and why the position was established and also to elicit information and opinions about how the NP functioned as a leader within local, state and national levels. Participants included representatives from the medical, nursing and allied health professions, as well as managers

and policy advisors at local and state levels. Sampling concluded after ten interviews as the there was enough evidence to address the research questions, the data were rich and thick, and there was no new information being presented. Arguably, saturation of data had been reached (Richards & Morse 2013). Primary quotes from participants are indented and presented in italics in speech marks throughout this case study. Table 4.2 below provides an overview of the research participants.

Table 4.2: Research participants

Participant
Nurse Practitioner
Geriatrician (medically trained)
Manager, Community Health site, small rural hospital
Nursing Unit Manager, acute care, regional hospital
Senior Manager, Local Health District (non-nursing background)
Nursing Representative, Aged Care Assessment Team
Psychiatrist
Social worker from an outreach service for older people
Senior Policy Advisor, NSW Health
Manager, residential aged care facility

All participants were initially contacted by email. Eleven participants were contacted, and ten responded and agreed to participate. Gaps identified from the one person who did not participate in the study were filled by asking further questions of the other participants. Those who agreed provided written consent to participate in the study (Appendix 1). Once agreement was given, the participants were contacted by phone or email to set up mutually agreed times and locations for the interviews.

Half of the interviews were held at the participants' workplace in a quiet room. The other interviews were held in a quiet room in the researcher's workplace for the convenience of the participants. The NP was interviewed on two separate occasions to gain an insight and understanding of the NPs work. The second interview enabled further questions to be asked and provided an opportunity to explore issues raised by the participants, to confirm analysis and address questions remaining after the first interview.

All interviews were digitally recorded and transcribed with participants' permission. Field notes were taken immediately after each interview to capture the mood and anything that was said that was unusual, and to summarise any important themes or ideas (Braun & Clarke 2006). Interviews ranged from 30 to 60 minutes. Questions were planned prior to interviews, based on

the study's research questions, to guide the sessions. Please see Appendix 4 for the interview guide.

It is interesting to note that three of the participants interviewed had worked alongside the NP over a significant number of years before the NP position was established. The NP had previously worked in another advanced nursing role in the Local Health District, and had also had senior roles in aged care. Because these participants had been in the setting before, during, and after the NP role was implemented, they provided insight into how the goals and aims of the potential role were developed, and how the role was accepted over time. One medical participant had worked successfully alongside other NPs outside Australia and had developed a high level of respect for the NP role. The participants interviewed all worked closely with the NP. In an effort to reduce the effect of researcher bias in the study, one supervisor listened to all of the interviews and read the transcripts, and detailed discussions ensued regarding how the data were interpreted.

4.6 Documentary Evidence

A range of documentary evidence was used to understand the context of the role and to describe it. Whilst the documents were not coded, they added background information and breadth of understanding to the case study. The documents were read and re-read within the context of the other data gathered and discussed with the NP, as well as the supervisor.

4.7 Observation

The NP was directly observed in two separate formal meeting settings, at local and state committee meetings. An observation protocol adopted from Creswell (2012) was used to focus the observation in both of these settings (For the Observation Protocol, please see Appendix 5). During and after the meeting, the researcher took notes using Creswell's (2010) protocol on what she heard, experienced and thought about during the meetings. The Chair of each meeting was provided with copies of consent forms and participant information sheets, and verbal consent was obtained by the Chair from each of the participants before each meeting. During these meetings the researcher remained a direct observer and as unobtrusive as possible, and watched the committee meetings as opposed to taking part. The researcher recorded the characteristics of the meetings and the roles taken by the NP.

Table 4.3 Documentary evidence used in Case Study 2

Document	Source
Nurse Practitioner standards for practice 2014 (Nursing and Midwifery Board of Australia 2014b)	Nursing and Midwifery Board of Australia
This Nurse Practitioner's Scope of Practice Document	Nurse Practitioner (personal communication)
Draft state plan for Older People at Risk March 2014	Nurse Practitioner (personal communication)
Dementia E-learning Survey Report 2012	Nurse Practitioner (personal communication)
Terms of Reference and Minutes of Psychogeriatric Reference Group	Committee Meeting Chair (personal communication)

The first committee meeting observed was a high-level state-wide committee that provided expert advice to the NSW Government and Ministry of Health to improve patient care, address inequities in access and reduce avoidable hospital admissions.

The focus of the meeting was the development and implementation of a state-wide guideline on the key principles for individual patients at risk who require one-on-one nursing care. The NP was the only NP at this meeting. Other members included Clinical Nurse Consultants, Clinical Nurse Specialists, Nurse Managers, and Clinical Nurse Educators from the Local Health Districts. By observing the NP at this high-level state-wide meeting, the researcher was able to observe her input into state-wide guidelines, her advanced knowledge and skills, her interactions with other committee members, her influence in how guidelines were developed and implemented, and her influence in representing rural areas.

The second committee meeting was a local psychogeriatric reference group. Again, this provided an opportunity to observe how the NP interacted with her peers at a local level and how she influenced best practice and reported on key findings and guidelines from state and national levels. Representatives from a range of services for older people across a number of locations and representing community settings were present. The meeting was video-conferenced to a number of small rural sites. The agenda for the meeting focussed on the implementation of education and clinical competencies across sites. The NP gave updates on the various state-wide committees and reference groups she belonged to, as well as reports on a number of continuing professional education events in aged care. As part of the meeting, committee members had a discussion about the importance of the NP role in providing an

interface between the hospital and the community. This was reflected in the literature and in one of the key findings of this research.

4.8 Data Analysis

Thematic analysis (Braun & Clarke 2006) was used to analyse the interview data. The aim of the data analysis in this instance was to provide a rich thematic description developed from the interviews and documents in Case Study 2, to describe the NP in context, and to investigate the NP's role in leadership in a primary health care setting.

The first step in the analysis for Case Study 2 involved becoming familiar with the data as a whole. Firstly, the interview recordings were checked against the content of the transcripts to ensure transcription accuracy. At the same time, any identifying data such as names of people, places or towns were removed to protect the identity of the NP and the participants. Secondly, the researcher read each of the interview transcripts and field notes, as well as the documentary evidence, several times to become familiar with the overall data set. During this phase of initial reading and reflecting, notes were taken to record initial impressions, identify and note key points raised and consider how each data source reinforced, extended or challenged previous sources. In this way, the initial analysis began, aimed at depicting the NP's role and how leadership was demonstrated by the NP. In addition, notes on interesting and important observations and initial ideas were collected for coding (Braun & Clarke 2006).

The next step involved organising the data into meaningful groups (Braun & Clarke 2006). Broad initial codes were generated, based on the research questions as well as emergent codes from the literature. The entire data set was then coded systematically. Using *NVivo 10* software, selections of the text were tagged under meaningful groups or categories. In some places, individual extracts of data were coded across a number of broad codes. The first category related directly to the NP's role:

- Establishment of the Nurse Practitioner's role
- Description of key characteristics of the Nurse Practitioner
- What has changed since the Nurse Practitioner role/position was implemented
- Barriers to implementing the Nurse Practitioner role
- Description of the Nurse Practitioner role at local, state and national levels

- National Nurse Practitioner standards related to leadership:
    - Assessment
    - Planning care and engaging others
    - Prescribing and implementing therapeutic interventions
    - Monitoring outcomes to evaluate improved practice.

The second group of codes related to the WHO domains of leadership (Flahalt & Roemer 1986):

- Integrity
- Initiative
- Enthusiasm
- Experience
- Sound knowledge.

During this early development of the coding structure, one of the research supervisors independently coded a full transcript using the initial broad and second group of codes. This coding comparison in *NVivo 10* showed high levels of agreement in the majority of codes and highlighted areas for discussion and refinement and development of the coding structure. For example, discussion ensued regarding use of the *Planning Care and Engaging Others* code as an overarching category which also covered important topics of mentoring, teaching and developing others. Phase 3 of the analysis was based on searching for themes, as described by Braun and Clarke (2006). This step involved looking at the relationships among the categories and the development of key themes.

The most significant part of the analysis involved creating an overall narrative about the data and describing the broad categories and themes captured, comparing differences across what different participants said, and looking for patterns. The findings were also compared with the literature and are discussed in the results section of each case study chapter. The themes were given more concise and succinct titles and a model developed describing overall the leadership role of the NP (Figure 4.1). A summary of the findings was discussed with the NP to verify for accuracy and to see if the analysis made sense and could be confirmed by the NP.

4.9 Results

4.9 (a) How and why the Nurse Practitioner model was established

Documentary evidence and consistent contributions from participants showed that the NP role was established as part of the NSW Dementia Action Plan (Department of Ageing, Disability and Home Care 2002), which identified the need for dementia specialists. Part of this Action Plan

was the allocation of funding for ten dementia Clinical Nurse Consultant (CNC) positions across the state. A clause in the funding agreement allowed for the transition of the CNC positions to NP positions. The initial role of the CNC was to raise the profile of dementia among community services, external partners such as residential aged care facilities, and acute services. The role also had to look at policy gaps and procedures at a local level and the clinical processes and assessment tools for the management of dementia. The NP in this study commenced as a dementia CNC in 2004 and later transitioned to an NP. At the time of this study the NP had been working in the NP position for over 5 years. The NP position received ongoing funding as part of the new state-wide dementia action plan.

Analysis of the data from the interviews, documentation and observation showed evidence of the leadership role of the NP. Overall characteristics of the NP were identified, as discussed below. Additionally, the data provided examples of innovation, enthusiasm, initiative and integrity, and advanced knowledge under four key themes:

1. The NP as an educator
2. The NP as a mentor
3. The NP as an advisor and advocator
4. The NP as a leader in integration.

These themes demonstrate how her leadership was "operationalised", and how her role influenced, supported and motivated her peers to collaborate with her. The themes also illustrate how she reformed and improved current practice, challenged processes and implemented consumer-focussed health care. These key themes are illustrated in Figure 4.1.

4.9 (b) Characteristics of the Nurse Practitioner role

The NP established a network with very high profile people from a range of institutions and aligned herself with people who supported her to achieve. She used her abilities to bring people together to establish reference groups and committees.

> *"She is very passionate about what she does and has a willingness to stand against resistance." (Psychiatrist)*

The NP became recognised as a resource at local, state and national levels.

> *"She is a driver at a state level."* (Manager, Community Health site, small rural hospital)

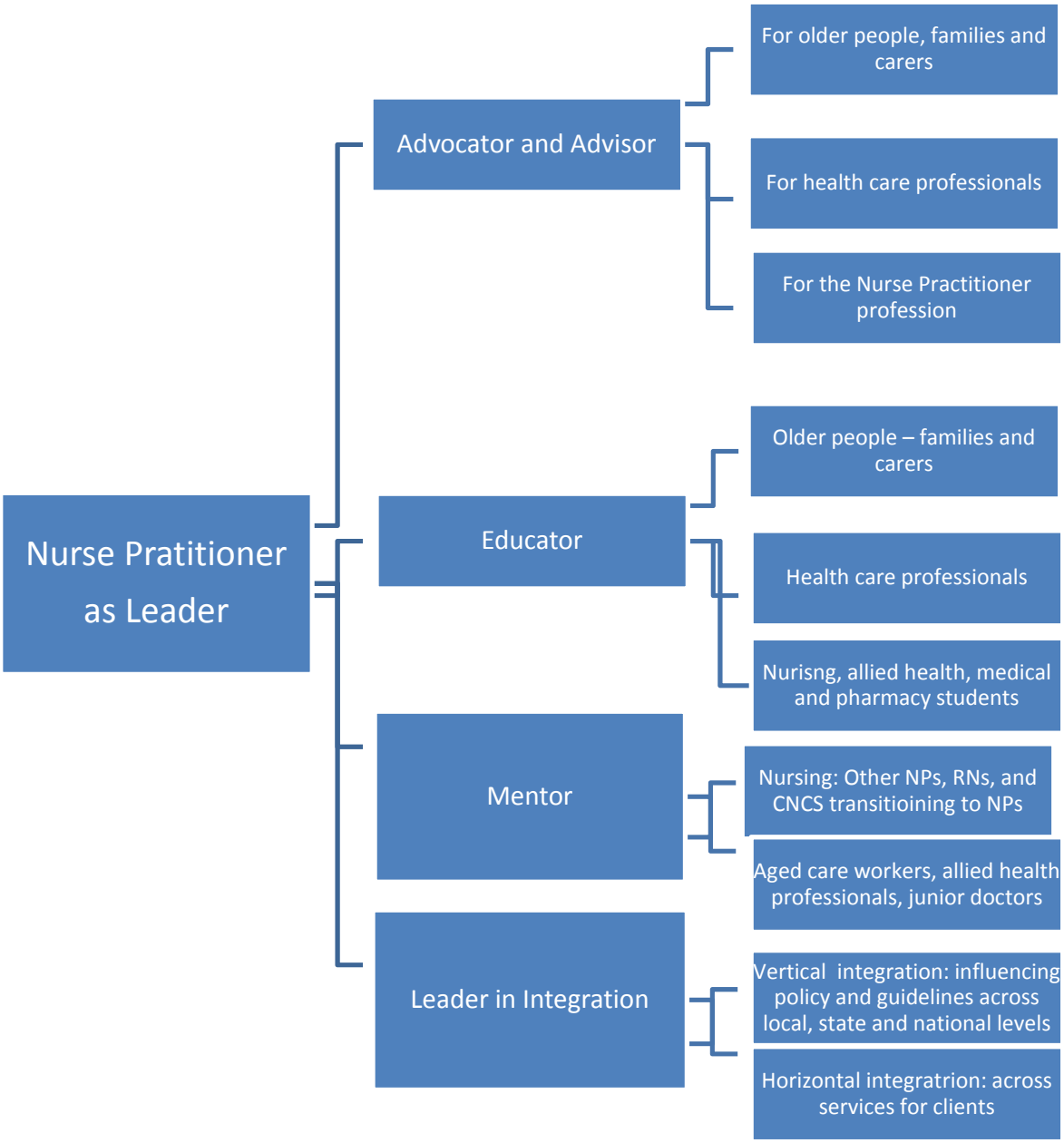

Figure 4.1: The Nurse Practitioner Leadership Model

Several of the senior managers described the complexity of her work, including the breadth and depth of where and how she worked across a broad range of services at local, state and national levels.

> *"She could be getting calls from a relative about a patient in hospital, while taking a referral from a clinical team and then she could receive a call from a state or national official."* (Manager, Community Health site, small rural hospital)

A senior policy advisor from NSW Health described her work as *persistent* and *value-adding*.

The findings showed that the NP had earned respect and credibility from senior clinicians, including medical peers and senior managers. This enabled the NP to influence client outcomes at local, state and national levels. The NP's skills, knowledge and experience were clearly valued by the physicians who referred their patients to the NP and worked collaboratively with her. The NP also received referrals from nursing and allied health clinicians. The NP was consulted by others, including senior managers– not just clinically, but in other areas such as the establishment of other NP roles and the setting up of new hospital departments.

> *"The NP is plugging a gap in rural services that would otherwise have very limited access to this specialist service."* (Geriatrician)

The NP showed leadership and commitment beyond the norm for most clinicians. For example, she was responsible for transforming models of care and service delivery provided to older people who were at risk of or diagnosed with dementia or delirium.

Her practice was innovative in that it was individually patient-focussed and worked across a variety of settings and across a number of small towns – a paradigm shift away from the way that care was traditionally provided to older people with complex needs, centred around a hospital or residential aged care setting. The Geriatrician was closely involved as a mentor/supervisor in the formal NP authorisation process and demonstrated a thorough understanding and appreciation of this process, including an appreciation of the NP's courage and perseverance.

> *"It made me realise how in depth the attainment process was."*(Geriatrician)

The NP had over twenty years' experience in the speciality. She was described as having a unique and valued skill base.

4.9 (c) The Nurse Practitioner as an Educator

Education in a broad sense was seen as a major role of the NP and was frequently described by participants. The NP as educator was reflected in the documentary evidence and observed in committee meetings. This NP was shown to be leading the way in how education was provided to the system, both to individuals and teams. Examples were given at a local level where she had developed clinical champions across sites and services, implemented a range of clinical competencies and policies, and developed a facilitated online professional development program that is now nationally and internationally recognised (she has educated 160 facilitators across the state and has seen over 2500 clinicians complete this program). Additionally, at a local level, results show that the NP was perceived as a resource for the whole of the health service. At a state level she provided leadership to the implementation of state-wide action plans, policies and guidelines through the online professional development program. The program brought together the best dementia information the world had to offer, in order to improve the life journeys of people living with dementia and those who provide the care.

Participants reported that the NP provided clinical advice to a range of nursing, medical and allied health clinicians. Everywhere she went she engaged in teaching and mentoring colleagues, planning patient care and engaging others, and generally building the capacity of qualified staff. She had identified champions in a cascade model, meaning she was not individually offering all the education herself.

> *"She uses a cascade model of training, getting champions in place."* (Geriatrician)

> *"She realises it is too bloody big to do on her own."* (Senior Nurse Manager)

The NP provided clinical advice and support to allied health clinicians, medical staff and policy advisors.

> *"Everyone doesn't see her as exclusively dealing with nursing [sic]."* (Manager, Community Health site, small rural hospital)

> *"She provides advice in a way that is not critical but adds value... She displays persistence and enthusiasm and knows her topic."* (Senior Policy Advisor)

The Geriatrician described the NP as a consultant and on the same level as himself, and reported that the NP's expertise was also recognised by his other colleagues, such as the surgeons. She was also reported to be a great support for the junior doctors.

> *"I see her as a peer; I learn more from her than she does of me."* (Geriatrician)

> *"It's [holistic multidisciplinary care for older people with dementia and delirium] just not well done in other places or anywhere in the world... I know her opinions are respected by the senior doctors, because I can see that in the conversations that they have."* (Geriatrician)

The NP was described as:

> *"…a driving force for learning and development…"* (Manager Community Health site, small rural hospital)

Colleagues described reciprocal learning from working with the NP.

> *"She instils in some of the staff a desire to be good at their role and to learn."* (Manager, residential aged care facility)

> *"She also conducts training at the residential aged care facilities, and reviews resident notes, medications and behaviour plans, and she also observes particular residents and interacts in the setting."* (Manager, residential aged care facility)

The NP also retained her role in educating patients, carers and their families as a clinician. She also provided supervision for nursing, medical and allied health students on a regular basis, supporting the recruitment of clinicians to rural areas.

These results clearly demonstrate the NP's leadership characteristics regarding the theme, "Nurse Practitioner as an educator". Her ability to support and motivate others, her enthusiasm, initiative and integrity, and her innovative approaches to how she educated others, as well as her high level of advanced knowledge, all illustrate markedly the NP's leadership as an educator.

4.9 (d) The Nurse Practitioner as a Mentor

The NP in this setting showed evidence of mentoring and coaching other nurses, senior clinicians and other health professionals:

> *"[The NP] plays a really important strategic role… aged care services and senior clinicians go to the NP for advice as well as mentoring. [The NP] provides high level clinical access to the small outreach hospitals and residential aged care facilities and has been mentoring and supporting staff focussing on succession planning."*(Manager, Community Health site, small rural hospital)

The NP played a strong role in mentoring and supporting other nurses who were transitioning into an NP role or working towards their NP authorisation. She mentored and supported both local and interstate nurses during their transition and authorisation processes.

4.9 (e) The NP as Advocate and Advisor–Advocate for older people

The NP advocated at local, state and national levels for improved care and policy decisions that affect the health and quality of life for older people in rural areas. Her knowledge and experience were focussed across a wide range of services for older people. The NP strove at every level to get systematic and sustainable change. Participants described her as:

> *"...a phenomenal advocate for older people. …I have seen her achieve things with patients who no-one else has achieved …people utilise her lot …she has always functioned ahead of the pack."* (Geriatrician)

> *"She has certainly lifted the profile of aged care across the organisation."* (Manager, Community Health site, small rural hospital)

> *"[As a result of her advocacy for older people] patients are being dealt with more holistically, there is a bigger awareness of the person as a whole..."* (Geriatrician)

The NP was reported to have a very strong commitment to working collaboratively and through partnerships to help make changes happen at national and state levels. She strove to achieve systems change and did this by developing and maintaining strong working relationships, trust and rapport, and empowering clinicians across a range of services to deliver appropriate care. Her advocacy and mentoring work resulted in further NPs in this speciality being implemented locally as well as nationally.

> *"She is very resourceful at gaining the support of highly skilled clinicians. She has been instrumental in pushing forward a number of key changes regarding how clinical matters are addressed."* (Senior, Manager Local Health District – non-nursing background)

> *"What sets her apart from other clinicians is that she realises that unless you fix up the policies, procedures, the structures and the funding, then you are not going to get any systematic or sustainable change in how we deliver our services."* (Senior Manager, Local Health District – non-nursing background)

Part of her role also included a consultancy role to residential aged care facilities, where she provided advice, support and education. When a residential aged care client entered the hospital system, the NP would make initial contact with the client, complete a thorough

assessment and provide ongoing care and support to the client and the family until the client is transferred back to the residential aged care facility. For complex clients, she would then provide ongoing support to the residential aged care facility, providing one-on-one education to staff, recommendations to the visiting GP, and any other necessary referrals, for example, to a dietician. This contact with other health care agencies helped to make the transition of clients to and from hospital to residential aged care facilities run smoothly and enhanced the acceptance of the NP by the community and residential aged care staff.

In consultation with senior management and primary health care providers, the NP and the Geriatrician established a fortnightly outpatient clinic. This allowed patients to be reviewed by the NP instead of having to wait up to four or five months to see the Geriatrician. The NP led this clinic and saw older at-risk patients who had been in the larger regional hospital and who required follow-up after they were discharged from hospital. She also saw patients at the outpatient clinic who had been recently diagnosed with dementia by the Geriatrician. The NP saw these patients on an ongoing basis, and in this way provided support to both the patient and the family. An example of an ongoing patient that she saw at the clinic was described by the NP below:

> *"Recently I saw a 57 year old gentleman who has Down syndrome and dementia. I have been seeing this man in the community for about 2 years as well as in my clinic. He is cared for by his mother, sister and his brother in law. On this day he came into my clinic in a wheel chair which is quite unusual, normally he walks into see me. He had a swollen right leg and I was concerned about that. I looked at his leg and the story was that he had fallen a week before and injured his leg. I looked at his leg it was very bruised in the thigh area and all around the hip. He was having trouble voiding. He had presented to the local hospital, and they x-rayed his knee and said that there was nothing wrong with his knee and sent him home. He had also presented to his GP who had his ankle x-rayed and there was nothing wrong with his ankle and sent him home. Then he came to my clinic and clearly this man had a fractured neck of femur. So I organised an x-ray and he was immediately admitted to the regional hospital for surgery. I saw him in hospital before and after his surgery and jointly managed his care with the orthopaedic team. I had to put in some particular strategies in place with the staff that were caring for him for example how to engage with him, how to be alert for signs of delirium and I also supported his family. I will continue to follow him up in the community when he is discharged from hospital."*(Nurse Practitioner)

This is an example of how this NP advocated for her patients. She did not take for granted the diagnosis of the GP or the emergency department. She showed initiative and integrity and acted on her advanced knowledge and experience. She led the care for this patient, managing

this acute episode of care in the community, and continued to see him daily whilst he was in hospital. The NP was seen as the primary provider of care for this patient and also an integral part of a care team. Her care included an holistic assessment and management plan for the patient, including general medication and pain medication reviews with the pharmacist and GP, liaising with allied health staff to assess his diet and nutritional status, discharge planning, arranging a home visit review with the occupational therapist, and communicating with the GP and nursing staff as well as the patient's family and carers in the planning of this patient's care.

The knowledge and skill base of this highly specialised NP, together with her cross-sectoral leadership, makes a strong case about the potential for NPs in rural settings.

4.9 (f) The NP as Advocate and Advisor –Advocate for nurses

The NP advocated for nurses as well as patients. An example of this is the support she gave Nursing Unit Managers to gain more nursing hours to care for patients with dementia. Her colleagues also recognised that her advocacy improved patient outcomes and collaborative team work:

> *"She's very supportive of nurses and NUMs… when we have heated discussions around specialling[one on one nursing care] when, you know, Executive are trying to get us to special within our nursing hours for a patient bed day and we all know that that's absolutely not, not doable and then we, we, employ a special. The NP will often advocate for, us as NUMs to say, you know, how can you expect them to put this patient in nursing hours when they're up wandering around the corridor and, you know? She, she's a strong advocate and that comes back to patient safety. So, very strong advocate for patients and nurses."* (Senior Nursing Manager)

> *"There is a greater awareness of looking at the older person more holistically and patient outcomes have improved significantly. There have been better referral pathways established, out to the specialist teams such as older persons' mental health."* (Geriatrician)

> *"She's pretty well greatly respected… she's one of my mentors, I guess, in nursing and, and I hold her in great regard and I guess that probably has influenced, um, the acceptance of her."* (Senior Nurse Manager)

The NP was able to offer support to nurses at the small rural hospitals which did not have access to a Geriatrician. She would visit these small hospitals monthly, or more frequently as requested by the nurses and/or the GP, to assess difficult or more complex patients. She provided a service to patients and some modelling and supervision to staff.

4.9 (g) The Nurse Practitioner as Advocate and Advisor –Advocate for Nurse Practitioners

At the time of the study, the NP represented NSW NPs, and gathered issues for NPs and fed these up to the national body. She was successful in lobbying senior management to have two further similar NP positions put in place within her own area.

4.9 (h) The Nurse Practitioner as Advocate and Advisor –Advocate and Advisor for rural communities

The NP sat on a number of local, state and national committees and advocated for rural patients and their carers.

The NP's work was described by senior policy advisors and local managers as being influential on these committees, leading to the development of various guidelines and assessment tools, but, most importantly, making a difference at the coal face in rural areas. For example, the Geriatrician described the influence that the NP had in being involved in local, state and national committees. The NP kept up to date with guidelines and policies and also influenced them, having a real impact at the local level on patient care. He saw this as very important. The NP was also involved with the development of documents, including strategic and clinical service plans at local and state levels. She also made reports to the state-wide and national committees, and also reported state and national level changes locally.

> *"She is involved in a variety of state committees...she is in there with others writing the documents that produce state and national guidelines such as the dementia action plan."* (Senior Nursing Manager)

> *"[The NP is] an important advisor for the development of the NSW Dementia Services Framework."* (Senior Policy Advisor, NSW Health)

The NP was also an important member of the network of the dementia/delirium CNCs. She played a really important role in her area for advocating for people with dementia.

> *"She would be across all of the elements of dementia from prevention, the early intervention, diagnosis, links to community support and management in acute care. She would have been influential in getting the local dementia plan up and running. There weren't many medical experts in this speciality over time and the NP has developed clinical expertise on that area and been a resource for local clinicians. She has been an active member in providing advice to state policy documents. She has had good liaison with the dementia training study centres at a national level. She provides specialist*

advice and complements what the other committee members have to say on these state wide committees." (Senior Policy Advisor, NSW Health)

"The NP has the opportunity to meet one-on-one with a number of bureaucrats and policy advisors at a state and national level. Her role has been crucial in pushing forward a number of key changes regarding how clinical matters are addressed in rural areas." (Nursing Representative, Aged Care Assessment Team)

The NP was also invited to be a specialised representative on a number of ministerial committees. These committees were charged with looking at regional and rural issues and what structures and models of care are required in these areas. How the confused older person is managed in hospital has now become an issue on the Australian Safety and Quality Commission, due to the NP's expertise and presence on these ministerial committees.

In another example of local, rural advocacy, the NP wrote modules for the nursing curriculum at a local rural university and was actively involved as part of the nursing curriculum review for the university.

The NP contributed to the design, refinement and implementation of a number of screening and assessment tools, as well as policies, action plans and guidelines at local, state and national levels, that all were able to be applied to small rural hospitals. These included the following:

- State-wide Dementia Action Plan
- Local policies on restraint, delirium, cognitive screening and the management of incontinence
- Guidelines for restraining older patients (National)
- Guidelines for providing a "special" (one-on-one nursing care) to older confused patients in hospital
- Delirium guidelines and pathways (National)
- Cognitive Assessment Tools and competencies (local – this project was the winner of the recent Local Health District quality awards)
- Integrated framework for the care of older people (state-wide as part of the Aged Health Network for Agency for Clinical Innovation.

The NP was also asked for opinions on different models of care, in particular, the design of an aged care unit at a regional hospital, as well as the establishment of the acute services emergency team at this hospital.

> *"She has certainly lifted the profile of aged care across the organisation, the promotion of aged care so that it is seen as everyone's business."* (Senior Nurse Manager in rural hospital)

This NP represented rural communities on a number of committees. She ensured that decisions about rural health care were made with input from an experienced clinician who was close to patients and who knew and understood her and her patients' community. She became a voice for rural nursing in NSW and nationally.

4.9 (i) The Nurse Practitioner as a leader in integration

The NP described had a very innovative and reformative role. She practised across a large number and variety of settings and was actively involved with coordinating care from many different professional colleagues in managing clients with complex needs. Overall, the NP was part of a multidisciplinary team where she managed care jointly with a range of clinicians from a range of settings, planning care and engaging others. For example, a patient's care may have been managed with the orthopaedic team, the pharmacist, the GP and, in some cases, staff from residential aged care facilities.

> *"She has a much broader audience than just nursing... she supports community and residential aged care providers, staff from ACAT and dementia outreach, and staff from non-government organisations."* (Manager, Community Health site, small rural hospital)

At a horizontal level she coordinated care for clients and their families, and at a vertical level she integrated services from local to state and national levels. Participants described the NP as being able to break down barriers and improve communication between agencies. She delivered services across a number of small towns. The NP described the importance of her work in having the ability to bring a range of clinicians together to develop a package of care that was focussed on the individual patient. Also, what is significant was her ability to look beyond the initial clinical problems that presented to focus on a holistic plan of care for each patient.

> *"It's not often only the broken arm or the cellulitic leg of the heart disease in geriatrics, it's the other complicated presentations and the symptomatology that comes with the person, you know, it could be dementia, it could be delirium, it could be an anxiety*

> *disorder. So we fix the broken leg, but the person is significantly cognitively compromised. Medicine and surgery can resolve the acute presentation but nursing brings with it all of the other surrounding issues and as the NP you have the ability to bring all of those clinicians together to resolve all of the problems that the older person presents."* (Nurse Practitioner)

This was reinforced by observing the NP at local and state-wide committee meetings. At both local and state levels she was highly recognised for her knowledge and expertise, and her initiative and integrity. She was continually asked to comment on suggestions and to provide feedback. Her enthusiasm for her specialist field of work, as well as her ability to influence, support and motivate peers, improve current practice, challenge processes, and drive and implement high-quality health care, were evident.

The NP was able to establish therapeutic relationships with each patient, providing a comprehensive assessment, examining all of the health issues of the patient and consulting with a range of clinicians to provide comprehensive care.

> *"Nursing brings with it all the other surrounding sorts of issues, the carer issues, the financial issues, and then one by one she tries to resolve some of the problems that the older person presents."* (Nurse Practitioner)

This case study has shown that the NP was a key leader in integration. She provided a collaborative service, through joint planning and partnership involving a multidisciplinary range of rural clinicians across multiple providers. This enabled the delivery of coordinated and comprehensive care for older people with complex needs. This care coordination involved a continuous exchange of patient information among health care providers. The NP integrated communication and care among residential aged care facilities, community health centres, small rural hospitals, General Practitioners, Aged Care Networks and the larger regional hospital. She improved linkages among primary, speciality and acute services.

> *The quality of care of residents has improved because of the knowledge and the professionalism that she brings."* (Manager, residential aged care facility)

The NP attended monthly case review meetings at the smaller sites where she discussed clients at risk in the community (e.g. people with challenging behaviours or mental health problems) with the community nurses and General Practitioners. She also provided clinical advice for these patients and if necessary did home visits to assess these patients in the community. The NP also went to two multipurpose services once a month and reviewed the more complex inpatients in the aged care units attached to these, in consultation with the General

Practitioners and nursing staff. She reviewed all aspects of patients' management, including their medication, mobility and overall treatment.

The NP developed an interagency communication tool, an easily recognisable document used when people living in residential aged care facilities were admitted to or discharged from hospital. This is an example of how the NP coordinated care with other health, disability and aged-care providers, agencies and community resources.

> *"It's not an ideal situation to send a resident with advanced dementia to hospital but the whole process seems to work a lot better because of the systems that the NP has implemented. She would have a protocol in place for these complex patients and would oversee their management. A protocol that she was involved with implementing…is a transfer document that contains care plans, medication chart, next of kin details, advanced care record, details of power of attorney and their immediate care details in a short succinct summary."* (Manager, residential aged care facility)

4.10 Discussion

The NP in this study greatly demonstrated her leadership ability and reflected the definition and qualities of leadership provided at the beginning of this study. She showed considerable ability to motivate her peers, and her advocacy in standing up to senior management to implement further NP roles was exemplary. The NP's innovative model of online education supported clinicians from within and outside her workplace and expanded to clinicians across Australia. Her knowledge and experience were recognised by senior doctors who saw her as a peer who supported their practices. The NP also contributed to national and state-wide policies that led to safe care and collaboration among health care teams and services.

The NP showed a willingness and ability to advocate at a systems level for older people in rural settings. She had support and collaboration from a range of clinicians and senior managers across a number of small towns and services, including allied health, nursing and medical practitioners who understood how the NP role worked. Sullivan-Bentz et al.(2010) and Conger and Plager (2008) also confirm the importance of having clinicians such as physicians, nurses and administrators understand how the NP role works in order for new NP positions to be implemented smoothly (Humbert et al. 2007).

Mills et al. (2010) and Sullivan-Bentz et al. (2010) recommend that NPs receive formal mentorship and support. The NP received valuable mentoring by the Geriatrician, which helped support her to carry out her tasks successfully.

The NP had over twenty years' experience in the speciality and had previously worked within the area and with some of the participants interviewed. She was described as having a unique and valued skill base. Sullivan-Bentz et al. (2010) also describe how increased support and more effective work practices arise when NPs work with colleagues with well-established mutual work histories (Sullivan-Bentz et al. 2010). This trust and respect from clinicians enabled her to break down barriers and improve communication among agencies (Conger & Plager 2008; Humbert et al. 2007).

Her connection with a range of services and clinical networks improved linkages among primary, speciality and acute services, as highlighted by Conger & Plager (2008).

4.11 Conclusion

This case study has verified the potential for NPS in rural settings to demonstrate and provide leadership. Case Study 2 provides evidence of an NP functioning and being recognised as an expert leader at local, state and, to some extent, national levels. Her role was strategic and worked effectively at all of these levels. The NP showed a readiness and an obligation to advocate for her clients as well as the nursing profession at the systems level of health care. Participants' reports and documentary and observational evidence showed that the NP was influential in decision-making and policy development across the system.

The context in which this NP was practising was significant, according to a number of participants, and she provided a service to patients that would otherwise not have been provided. It would not be sustainable for a Geriatrician to deliver this type of service. She provided a consumer-focussed service and worked in partnership with others across a number of settings. She provided professional development and support to staff across the state, as well as locally.

Her reach was described as extending beyond nursing, medicine and allied health into local, state and national policy and practice. This NP functioned at a broad systems level across a number of services, not only giving expert advice to clients and their families, but also to medical, nursing and allied health clinicians. She also provided advice to policy developers at state and national levels. Clinicians across a variety of settings showed acceptance and understanding of how the NP role worked, including the referral processes. Her practice was innovative, collaborative and reformative, and focussed on meeting unmet consumer need.

Chapter 5. Discussion

5.1 Introduction

This chapter brings together the key findings from both case studies and also discusses the characteristics of the Nurse Practitioners and their similarities. The limitations to the research overall are also discussed, as are suggestions for further research.

This thesis contains two descriptive case studies of two purposively selected NPs from a rural Local Health District in NSW and provides an opportunity for describing in-depth and in detail the implementation, roles and impact of NPs in rural health care settings. The variations between the two studies were geographic location, speciality and model of care, as well as the patient population. Other variations included the models of funding and management, and governance structure. Similarities between the two cases are discussed later in this chapter. This chapter discusses the evidence that was generated from the two case studies, as well as key lessons to be learnt when implementing NP roles in primary health care settings.

The two case studies have demonstrated the potential positive impact of having NPs in primary health care settings. At the time the study commenced, the latest figures (2009) showed twelve of 208 working NPs were located in primary health care settings in Australia (Middleton et al. 2011). These two case studies could enable others to determine the appropriateness of establishing similar NP service models in other settings or areas.

5.2 How and Why Nurse Practitioner Led Services Are Implemented in Small Rural Towns

These case studies demonstrate that NPs can effectively provide comprehensive specialised services to people in small rural towns where such services would otherwise be lacking. The shortage of a range of clinicians in rural and remote areas is well-known and discussed in the literature (e.g. see Cheyne-Macpherson2007; Larson 2010; Liaw & Kilpatrick 2008; Morrissey et al. 2007). These NPs have provided a much-needed continuous, ongoing and valuable service to small rural towns that previously would not have access to this type of specialised service.

The success of initial implementation of the NP roles was attributed to consultation with a range of key stakeholders, ensuring that everyone involved had an understanding of the NP role, the referral processes, governance, and funding and management structures. In Case Study 1, it was also attributed to being driven by the community. It is interesting to note, however, that this was not always demonstrated in Case Study 1, as acute care MH services did not fully support the NP role or understand how the NP role and referral processes worked. For

both case studies, the key stakeholders, from within and outside the health sector, needed to work together to establish the services. Managers needed to be willing to take risks regarding how these services were implemented and where they were located, and to think beyond the way health care is traditionally provided, including the provision of longer-term as well as acute care services. Case Study 1 also showed that key partners, such as regional and state governments and non-government organisations, and community engagement are also central in establishing this type of service.

This study's findings concurred with those of Sullivan-Bentz et al. (2010), Conger and Plager (2008) and Humbert et al. (2007), who revealed the importance of senior nursing leadership when implementing new NP roles. They argued that senior nursing leadership is important to ensure that all key stakeholders have a good understanding of the NP role and how it works, and to convince other key stakeholders to consider an NP led service. This was certainly illustrated in these case studies.

Once in place, the NPs need time to establish the role and to build a strong support network. Support and collaboration from a range of services is required to support the NP and to contribute to the success of the service. These services could include local General Practitioners (GPs) and other primary health care providers, hospitals and, in the case of Case Study 2, residential aged care facilities.

5.3 What Are the Key Features for Establishing Nurse Practitioners in These Types of Settings?

Case Study 1 shows that key influences in the journey to establish an NP service include strong lobbying and involvement by the community, the significant role of the regional government organisation in bringing the agencies and services together, and the development and signing of a Partnership Agreement. The role was not planned for an NP; however, an NP has filled it with distinction. The NP in Case Study 2 highlighted the need to convince senior managers and health care planners about the importance of NP positions. This study has demonstrated that acceptance of the NP role is dependent upon at least some of the key stakeholders, as well as other team members, having a prior knowledge of the NP role. In addition, Case Study 2 demonstrates that the acceptance of the role was facilitated by the key stakeholders having a long-term, established working relationship with the NP. This research demonstrates the need to engage key stakeholders, including community representatives, in the implementation and design of NP positions, so that all stakeholders are able to gain knowledge and understanding of the NP role. This emphasis on community engagement and local leadership is also described in other studies (e.g. see Bartels et al. 2004; Eager et al. 2005; Vesey et al. 2005).

5.4 What Do These Nurse Practitioners Do?

The NPs addressed service gaps in their towns, reduced the stigma of mental illness, managed and prevented acute mental health (MH) crisis situations, and provided ongoing care and support for clients, including providing and coordinating care for complex clients across multiple services, providers and settings. All of this has resulted in significant positive health outcomes for the towns and/or the services within these small towns and individual patients.

5.4 (a) Case Study 1

This NP addressed the gaps in MH services as outlined in the literature, including fragmentation of services, shortage of adequately trained MH and drug and alcohol (D&A) workers, gaps in inter-service communication, avoidable mental health crises and provision of care on a sporadic basis (Allan 2010; Bambling et al. 2007; Cleary et al. 2009; Hodgins et al. 2007; Taylor et al. 2009). The MH service provided in this small town was no longer centred on crisis management; nor did it have to continue to rely heavily on visiting MH specialists providing care on an irregular basis.

The NPs in both case studies had extensive specialised experience. They developed collaborative working relationships with and knowledge of the other providers within their speciality and sector and liaised effectively between these providers (Bambling et al. 2007). For the NP in Case Study 1, this collaboration made a significant contribution to improving access to MH services for the local population. The NP is able to respond immediately to distressed or violent behaviour in the main street if it is audible from within the NP's office (located in the centre of the town) or if notified by members of the community. She is highly experienced at dealing with these types of situations and can then diagnose, treat and refer these types of patients, as well as provide ongoing treatment and support. The NP provides an ongoing five-day-a-week service to this small town.

The NP in Case Study 1 was therefore able to develop trust and rapport, not only with her current clients but also with the community itself. This was evident from the increasing number of clients who self-referred and continued to see the NP on an ongoing basis, and even referred other family members and friends to her. The stigma of mental health, where people avoid the label of mental illness and decide not to seek or participate in care (Morrissey et al. 2007; Cheyne-Macpherson 2007), was reduced as more and more people accessed the service and got to know the NP. The NP was able to develop long-term relationships, trust and rapport with her clients, which in the long term enhanced their health and well-being. This approach is recommended by the *National Primary Health Care Strategic Framework, April2013* (Commonwealth of Australia 2013). What was also reported by participants about the

implementation of the NP service was the resultant reductions in incidents of crime and violence in the town. The successful NP led service resulted in many other positive outcomes. The population were able to access an experienced NP who addressed the *acute* needs of individuals as well as providing *ongoing* support and follow-up. This assisted these clients to reintegrate back into the community with social, housing and welfare support, and access other health care professionals. This type of service, described by Eager et al. (2005), also reduces the burden on carers and families and lessens the chance of repeat presentations to acute care services.

The NP developed effective intersectoral links with a range of other service providers such as Probation and Parole, and Departments of Housing and Immigration. She developed exemplary cross-sectional links, as recommended in the literature by Conger and Plager (2008) and Humbert et al. (2007). Additionally, she liaised across a range of health services and service providers to get the best long-term outcomes for her clients, as recommended by Kodner and Spreeuwenberg (2002). The NP was able to coordinate care for complex clients across multiple services, providers and settings. Participants articulated specific benefits of having an NP rather than another type of worker. These benefits included: the fact that the NP can prescribe; the broader scope of practice offered by an NP; the high level of skill and assessment practices expected of an NP; their therapeutic capability and sound understanding of treatment options; and their autonomy (Carryer et al. 2007).

5.4 (b) Case Study 2

Case Study 2 identified an NP who is leading the way in how care is provided for older people in rural settings. Her role looked beyond leadership in clinical practice to influencing the "systems" level of health care, as described by Carryer et al. (2007) and Gardner and Gardner (2005). Her role was very specialised, and she worked across a number of primary health care settings. Arbon et al. (2008) and Bail et al. (2009) similarly reported on the potential for NPs in these settings, providing care to older people across a number of acute, residential and community settings, although their study focussed on trainee NPs, as opposed to this study that reports on actual findings of a qualified NP in the role. Participants' reports, and other documentary and observational evidence showed that the NP was influential in decision-making and policy development at local, state and national levels. She provided a service to patients and support to clinicians that would otherwise not have been provided.

The NP's reach was described as being beyond nursing, reaching across allied health, medicine, General Practice, and community and residential aged care facilities. There was strong evidence to support the NP's leadership role across the fields of education and mentorship, as an advocator, adviser and leader in integration, as discussed by Garrubba et al. (2011). Significant

about her leadership in education was her ability to provide professional development and support across such a broad range of clinicians. The systematic approach to training, encouraging teams to work together and to follow best practice guidelines, policies and procedures, is emphasised in the *National Primary Health Care strategic framework, April 2013,* (Commonwealth of Australia2013).

The NP in Case Study 2 developed an innovative online education program that became recognised at local, state and national levels. Her education program contributed to an integrated service using a system-wide language, system-wide tools and a system-wide approach, as reported in the literature as being beneficial (e.g. see Davis et al. 2004; Judd et al. 2007). The program is well-utilised and continues to be further developed, with extra modules increasing its applicability to an even wider range of clinicians. The NP also provides education and support to small rural hospitals and community health centres. This education is patient-centred and focuses on the implementation of new policies, protocols and guidelines. The emphasis on promoting multidisciplinary teams providing care and the awareness of referral protocols is supported by Bambling et al. (2007) as well as the *National Primary Health Strategy Framework*, *April 2013*(Commonwealth of Australia2013).

The NP built an integrated service requiring all participating clinicians to broaden their professional paradigms. According to Veysey et al. (2005), this process requires cross-training, cross-agency discussion, collaboration, and shared assessment and treatment planning. The fact that the NP mentors and develops champions in each service is significant for sustaining best practice.

The NP has been instrumental in mentoring other NPs and nurses working towards becoming NPs, and successful in increasing the number of NPs within the local area and across the state. She also puts forward a strong voice for rural NPs in regard to access to training and supervision or mentorship. She also lobbies the Australian College of Nurse Practitioners on issues regarding rural NPs' having access to travel costs and support from employers to access and attend meetings, conferences and forums to ensure current practice. The breadth of her work in advocacy and advisory roles is substantial, with many examples provided at local, state and national levels. The importance of this mentoring role to nurses in rural areas is further highlighted by Mills et al. (2010) and Sullivan-Bentz et al. (2010) who state that mentoring is an important element for preparing and integrating NPs into rural primary health care settings.

5.5 What Contributes to the Success of Creating and Maintaining These Nurse Practitioner Positions?

It is important for the NP to develop connections with the community and to participate in activities to get to know the community and the community's culture (Conger & Plager 2008; Humbert et al. 2007; Sullivan-Bentz et al. 2010). The NP in Case Study 1 chose to live in the small community, thus enhancing her acceptance. She was seen in the street of the small rural town, was well-known and respected by business people and local services, and also had a strong working relationship with the local hospital and GPs.

The NP in Case Study 2 also developed connections and strong relationships with other services in her community. She had a very strong sense of collegiality, working collaboratively with a wide range of clinicians, including physicians, surgeons, GPs and allied health practitioners. She was also well-known and respected in the small rural hospitals, community health centres and residential aged care facilities in which she worked. To maintain these relationships, the NP in Case Study 2 attended regular case conferences and local committee meetings, and visited services on a regular basis, providing support, advice and education.

The context in which these NPs were practising also contributed to the success of these NP positions. Outside the acute care setting, both NPs had the capacity to collaborate with a wide range of professionals, services and agencies, breaking down barriers and improving communication and collaboration among services. Services were less fragmented, as described by Allan (2010) and Buchan and Boldy (2004). This is not always achievable for nurses who work only within acute care settings. The NPs had the ability to engage with and influence a wide range of services as their reach extended beyond traditional health-related services into other community services, and to support patients outside the acute hospital setting. As a result, patients were dealt with more holistically within the primary health care setting. This is in contrast to other rural primary care settings that experience a shortage of MH and other clinicians and where referrals to other health professionals rarely occur (Bambling et al. 2007; Hodgins et al. 2007).

Both NPs were able to fill gaps in rural services and develop strong partnerships within and outside the traditional health system. They applied the governments' health reform strategies by reducing the pressure on the health care system's resources (including other nursing staff) and funding (Williams et al. 2000). Both of the NPs also addressed the health workforce shortages, reduced the burden of the ageing population and chronic disease (NSW Department of Health2009), and provided better access to care for rural Australians (Australian Institute of Health and Welfare2006).

5.6 What Are the Barriers to Establishing and Maintaining Nurse Practitioner Positions?

The provision of health care to clients living in small rural communities differs from care offered to those living in urban areas, in the following ways. Small rural communities experience poorer health, and health outcomes decline with increasing rurality, as does access to services (Liaw & Kilpatrick 2008). In addition, rural communities have a higher proportion of vulnerable groups with greater health care needs. These groups include Indigenous Australians, farmers and the elderly (Larson 2010). To enable NPs to work in small rural towns, nurses, as well as other health care professionals, need adequate training and exposure to working in rural settings as part of their training. Having a strong sense of connectedness, experience and exposure in these rural settings, as well as the ability to consult and collaborate with a range of health care providers and other services, are essential in these settings (Conger & Plager 2008; Humbert et al. 2007; Sullivan-Bentz et al. 2010). According to a recent published study by Health Workforce Australia (2014), most nursing students complete their placements in acute settings, meaning they usually gain clinical experience in larger hospitals in metropolitan areas and lack rural experience. While the majority of placements occur in metropolitan settings (74%), a minority also occur in regional (25%) and remote locations (1%) (Health Workforce Australia 2014). Therefore, if nurses and other health professionals are not obtaining enough exposure to working in these small rural communities as part of their training, it is unlikely that they will have an understanding of how care operates within the primary health care setting or be motivated to work there.

There are many other challenges to establishing NP services in rural settings, and the development of a strong support network is essential (Conger & Plager 2008; Humbert et al. 2007). Being a sole practitioner, the NP in Case Study 1 was described as being at risk of burn-out. There were other risks, such as incompatibilities in referral systems, lack of integration with the acute care service, and uncertainty about ongoing funding for the position. The presence of a support person or a working group to help the NP establish and maintain rural connections is important. This enables the NP to understand the health issues of the community. It is also important for the NPs to have formal mentorship and support for incorporating the NP into a team, to assist with the clinical governance of the role and to assist the rural community to understand the NP role. The importance of developing working relationships with key stakeholders such as the GPs, community nurses and hospital clinicians, as well as a range of other services, is fundamental. The establishment of a mentor to discuss complex patient problems, reduce isolation, and help ensure good lines of communication was seen as important. The NP in Case Study 2 was mentored by the Geriatrician, indicative of the

recommendations made by Mills et al. (2010) and Sullivan-Bentz et al. (2010) that NPs receive formal mentorship and support.

The need for clear communication and referral pathways is essential, and this is difficult to manage across such a wide range of services. In these case studies, face-to-face meetings with staff from larger referral hospitals were essential to establish a wide understanding of the NP role, how it works and how best to establish communication methods across services. Coordinated meetings to discuss service provision and case review feature in studies by Anderson et al. (2011). This practice featured consistently in the NP in Case Study 2.

In addition, if the NP does not have any back-up coverage or administrative support, the NP can be at risk of burn-out. An extensive workload may also result in the NP's inability to attend professional meetings and formal education, meetings with a mentor, or case conferences at larger regional hospitals, making breakdowns in communication and disconnectedness from acute care services even more likely.

The establishment of a funding model to support new services is often difficult, particularly in an environment where services are fighting for funding (National Primary Health Care Strategy Framework 2013). Case Study 1 demonstrated that having one organisation provide funds for the service created a challenge to the acceptance of the NP role. Tensions between the services arose, especially as the acute mental health sector felt unable to meet performance targets due to funding being diverted to support the NP service. Also, this sole funding model would have contributed to the complexities in governance and reporting arrangements and sustainability of the service (National Primary Health Care Strategy Framework 2013).

An initial barrier for the NP in Case Study 2 was the large geographical area that she covered. This was overcome by the successful lobbying of the NP to senior management to implement further NP positions.

While the NP in Case Study 1 had made considerable progress in establishing a primary care led model of MH and D & A service provision, it was evident that more work was needed to ensure a consistent interface with the local MH service and provide coordinated care. Integration was also made difficult by the geographical isolation of the NP from the acute care MH and D & A facilities and the regional hospital. In addition, some members of the acute care team did not have a clear definition of how the NP could work with their services, or what her role and responsibilities were. Integration with the MH service was lacking in a few areas; for example, referral and documentation processes were not consistent or shared among services. Senior managers expressed concern that the NP, the most senior MH nurse in the area, was not integrated as part of the MH system and team. However, notable success in integration across

welfare sectors, the community, the small local hospital and the GP was evident. Suggestions to increase integration with the other MH workers included the NP participating in joint education and case conferencing programs with other MH workers, co-management of some clients, shared home visits, and opportunities for the NP to participate in MH team meetings. In addition, participants suggested further integration with the MH service could be achieved by having the NP work within the same MH protocols and systems and use the same reporting process as the MH services. Most participants thought having an NP in the role really added value, but this was not universal; one participant felt an RN could do the position just as well. The NP in Case Study 2 demonstrated a model where the pre-existing services became part of an integrated service and functioned as a coordinated service led by an NP. This model was also described by Anderson et al. (2011).

Barriers to the implementation of integrated services are widely discussed in the literature. These include an absence of clear service models, deficiencies in organisational culture, and an absence of integrated education and an experienced skilled workforce (Allan 2010; Bambling et al. 2007; Buchan & Boldy 2004; Cleary et al. 2009; Hodgins et al. 2007; Veysey et al. 2005). This study also identified other challenges to integrating services from an organisational perspective within health services, particularly with the acute health sector. It is difficult to effectively integrate services among organisations that have different agendas, priorities, systems and reporting systems, as well as management and governance structures (Kodner & Spreeuwenberg 2002). This study showed that for complex patients requiring intensive, ongoing medical and social attention from a range of providers over a long period of time, a combination of strategies is necessary to ensure integration is established and maintained. These key strategies include joint planning and decision-making, engagement of key stakeholders, clear referral processes, agreed referral protocols, and joint case management meetings.

5.7 The Impacts of the Nurse Practitioner Positions at Local, State and National Levels

At a local level, staff reported benefiting greatly from the NP service in Case Study 1. They saw her as a referral point offering continuity, and also benefited from the expertise of the NP in advising and guiding their own practices. Others, too, noted that the NP modelled how best to handle mental health and/or D&A crises and behaviours, not only for other professionals, but also the public in the street. The NP became a link between the community, the GP, the hospital, MH and D & A services, welfare agencies, the police and many non-government organisations. Her leadership was similar to that of the NP in Case Study 2; both NPs influenced and supported their peers, influenced decision-making and shaped the way care was provided

across a range of settings (Garrubba et al. 2011). Sound knowledge, experience, enthusiasm, initiative and integrity formed the foundation of the work of both NPs (Flahalt & Roemer 1986).

Locally, the NP in Case Study 2 was also instrumental in educating nursing, medical and allied health clinicians from a range of settings, including acute care in the larger regional hospital, small rural hospitals, community health centres, residential aged care facilities and non-government organisations.

Case Study 1 also illustrated how prior to the establishment of the NP service, little connection between agencies existed. There was also little evidence of collaboration among health and other community and welfare services, such as Probation and Parole, Community Services, Youth and Family services, the hospital, the police and general medical practice, as well as D & A services. Participants reported that prior to the establishment of the NP service there was poor integration between the hospital and local welfare services. This is consistent and commonly reported in the literature (Allan 2010; Bambling et al. 2007; Buchan & Boldy 2004; Cleary et al. 2009; Hodgins et al. 2007; Taylor et al. 2009). By locating the NP service in a non-government, non-health centre, a more integrated way of delivering community services resulted, and the NP led this.

Also at a local level, the NP roles positively influenced clients' health and well-being. In Case Study 1, participants described how clients were able to have immediate and ongoing access to MH and D & A services and that they accessed the service much earlier than beforehand. Additionally, the NP service enabled clients to access specialist mental health services more quickly than had previously been possible. Prior to the establishment of the NP post, discordance between the remit and approaches of the MH and D&A services was described as problematic for offering an integrated service to support dual-diagnosis clients. With the implementation of the NP service, this discordance was reduced, and dual diagnosis clients stopped falling through the cracks. This is a great example of where ongoing MH and D&A support is provided for clients in the community, thus addressing the recommendations outlined in state and national mental health policy documents (Council of Australian Governments 2012b; Department of Premier and Cabinet 2011; Roxon et al. 2011).

The NP from Case Study 2 has also had a positive impact at a local level. Integration of services and increased communication among health care providers resulted directly from the implementation of the NP position. Participants reported that the NP took referrals from GPs in small rural sites, Geriatricians, other medical specialists, nursing staff and allied health clinicians. She also travelled to the small surrounding hospitals at least once a month and participated in case reviews with the GPs and nursing staff. She coordinated care across a range of providers for older patients with complex needs. The NP showed leadership in planning care

and engaging others, as endorsed by the National Nurse Practitioner Standards of Practice (Nursing and Midwifery Board of Australia 2014b) and thus showed an example of how an experienced NP displays leadership. She provided her peers with support and motivation, as described by Garrubba et al. (2011).

This research also showed that the NP in Case Study 2 was instrumental in participating in the development of state and national policies and guidelines on caring for older people. The development of these guidelines supports integration by endorsing standards that are consistent across sectors, and promotes patient safety and best practice, as recommended by the National Primary Health Care Strategy in 2013. This component of the NP role also reinforces the wider systems level of leadership described by Carryer et al. (2007).

5.8 Characteristics of the Nurse Practitioners

In terms of personal characteristics, the NPs in Case Studies 1 and 2 had much in common. They worked in the same Local Health District; both had undertaken postgraduate education in nursing, had had decades of nursing experience and were highly experienced and respected in their specialties. These characteristics are reflective of an Australian National census of NPs conducted in late 2007 by Gardner et al. (2009),which showed the mean age of NPs to be 47 years, and also reflects the years of advanced clinical practice required before a Registered Nurse can be authorised as an NP (Gardner et al. 2009). At the time of this study, both of the NPs had been authorised for over 5 years, reflecting the newness of the NP role in Australia. The NPs both showed great strength personally and professionally in negotiating their career paths to become NPs. One of the NPs had previously lived and worked in the area before taking on her NP role, and the other NP was recruited externally from another area to the position. One participant, who was interviewed as part of both case studies, described the seniority of the two NPs in terms of age and experience, and how they had both worked in and trained in “old time hospitals”, giving them a breadth and understanding of the early history and development of their specialities. One of the NPs was described as being of the last generation of people who have had that range and depth of experience.

The NPs equally showed leadership and commitment beyond the norm for most clinicians and they both were responsible for transforming their services. The NPs both showed an ability to handle the distress and negativity reflected in the literature associated with the implementation of other NP positions (e.g. see Foster 2010; Mills 2010; Osmond 2008; Taylor 2007; Turner et al. 2007). Finally, both NPs had the support of their communities who showed an understanding of how the NP role worked, and, most importantly, the NPs both had universal support from their medical, nursing and allied health colleagues.

5.9 Further similarities across the two case studies

A strong theme of *integration* of services for managing clients with complex needs was evident in both case studies. As we know from leading rural health experts, *"integrated teams are vital to the health of people in rural and remote areas"* (Barclay & Hanley 2014, p36).

The services in both case studies showed innovative and contemporary models of care, allowing greater access to mental health or psychogeriatric services for rural populations that normally would have no, or very limited, access to these services. This innovation was not only seen in the practice of the NPs but also when these positions were originally established. The Chief Executive Officer and Area Director of Nursing, as well as other senior managers in the Local Health District, showed great insight in redesigning health service delivery to get the best outcomes for local populations. This innovative management is also discussed in the literature (Barclay & Hanley 2014). The theme of integration advocated so strongly by policy-makers was also evident when considering the level of community engagement that occurred with the planning, establishment and implementation of the MH NP position. Participants repeatedly reported that the community-centeredness of the NP contributed to a better integrated and accepted service.

Creating an integrated service is not simple to achieve, but its inclusion in key national guidelines regarding health services in rural communities shows how important it is seen to be (Australian Integrated Mental Health Initiative 2003 – 2009; National Primary Health Care Strategic Framework 2013). Using Kodner and Spreeuwenberg's (2002, p.3) definition of an integrated service, both case studies provided evidence of *"…connectivity, alignment and collaboration, within and between the cure and care sectors."*

The second strong theme evident across both case studies is how the NP role was valued and accepted. Except in the acute mental health team in Case Study 1, where a nursing participant lacked knowledge about the role of the NP, including the referral processes and funding of the NP position, there was little apparent resistance to the implementation of these NP positions from other nurses or members of the medical profession. Additionally, there was good evidence to demonstrate that medical and allied health clinicians had a good understanding of the role, along with the majority of the nursing staff. There was also evidence to suggest that the small rural communities quickly gained an understanding of the NP roles and benefited from accepting the NPs into their communities. It was also evident that the NP positions were valued and accepted at government, senior executive and health care policy and planning levels.

5.10 Reflections on Using Case Study Methodology

Using the case study as a methodology was particularly effective as it allowed the NP services to be described from the stakeholders' perspectives in the context of the small rural towns. The study gave an insider's view of how these positions were established in an unusual setting, how the NP positions actually worked, and what this has meant for the local communities in these small rural towns.

The use of case study methodology allowed in-depth examination of a considerable amount of information collected about the two NPs (Richards & Morse 2013). The data collected were rich and detailed (Richards & Morse 2013). The case study methodology included opportunities to visit some of the small rural towns and sites where the NPs provided services, leading to further insights. Being able to observe the surroundings, the NPs' practice locations, distances from larger regional hospitals, and people's behaviour added to the description of the NPs and their practices portrayed by all participants in the study.

Both of the NPs in this research were senior clinicians with many years' experience in their specialist fields. The findings of this study may have been very different with NPs who were less experienced or younger or who had had little support from the health service, clinicians and/or community and key stake holders. It is interesting to note that particular aspects of the NP services described in this study are unusual. In Case Study 1, the NP is located in a non-government organisation, providing mental health and drug and alcohol related services to a small rural town outside the traditional hospital setting. The latest figures in the second Australian NP census by Middleton et al. (2011) showed twelve of 208 working NPs were located in primary health care settings in Australia. However, none of these NPs was reported to be working within a community/primary health care setting (Middleton et al. 2011). In Case Study 2 the NP is even more unusual, as she worked in the field of psychogeriatrics.

The personal characteristics of the NPs themselves also influenced how the NP roles were accepted. This concept was reinforced in a study by Wilson et al. (2005). Acceptance was facilitated by the NPs having already worked within the health service, and having already developed relationships and rapport with clinicians and key senior managers. This was particularly evident in Case Study 2, where acceptance of the role was related to the participants' knowing and having a strong working relationship with the NP prior to the establishment of the NP role. Even when stakeholders who previously had no understanding of the NP role were involved, the fact that the NPs were already known helped their initial acceptance. As stakeholders gained more knowledge with further establishment of the NP roles, the numbers of clients accessing the service increased over time, as in Case Study 1. The findings may have been very different if either NP had been new to an area, or had not met or

worked with any of the key stakeholders. Additionally, the findings may not be transferrable to novice NPs or where Clinical Nurse Consultants are in a transition role, working towards NP status. Also, participants involved in implementing the NP role in other practice settings such as acute care may not have the same experiences.

5.11 Limitations of the Study

The health district where the NPs were located was opportunistically selected. Variation of the two NPs in the study included the geographic location, speciality and target population. However, having such a small sample size of only two NPs, and having both of the NPs in the study come from the same geographical area, limits the results of this study and the ability to generalise to other places, even rurally. The validity of the study could be strengthened by including further NPs or cases in the study across a wider geographical area. However, the in-depth descriptive content of the study would be lost, and the time frame and resources required would need to be considered.

Having had a role to play in the early implementation of several NP roles in NSW prior to this study, I may have been biased as the researcher. However, the use of documentary evidence and data sourced from a range of key stakeholders reduced this potential bias. In addition, the presence of research supervisors at some of the interviews, and their participation in reading through some interview transcripts and cross-checking the analysis of data further, also lessened any potential bias in the research. Additionally, research data were also confirmed by the NPs.

A NSW Health Authority implemented both of the NP roles in the same health district. Potentially, this could have influenced the outcomes, as the implementation of both these positions involved shared senior managers and bureaucrats and perhaps a common understanding and support for the NP positions. These senior managers were supportive of NPs and understood the role of the NP, which is not always the case (e.g. see Foster 2010; Sullivan-Bentz et al. 2010). It is also interesting to note that both of the NPs had initial and ongoing support from the medical practitioners with whom they worked. This was not always the case; there has been a great deal of medical resistance to implementing NP roles in Australia (e.g. see Foster 2010; Mills 2010; Osmond 2008; Turner et al. 2007).

5.12 Meeting the Challenges Presented in This Research

When reflecting on the design of this study, it is worth noting some of the challenges. First of all, because there were two case studies, two individual ethics and site-specific applications were required. Three separate literature reviews were also undertaken, one focussed on NPs in

rural primary health care roles, and two others specific to each case study. This was time-consuming. Two sets of data were created in *NVivo 10*. It was also difficult working on two case studies at the same time, as this required switching between cases and data sets. There was a large quantity of data from interviews, documents and observations across both of the studies, a common problem reported in the literature for case study methodology (Balbach 1999).

5.13 Suggestions for Further Research

Because of the scarce amount of research describing NPs within rural primary health care settings, further research describing these roles and how they work would contribute to the body of knowledge about NPs working outside metropolitan and acute care settings. It could maximise the current untapped potential for NPs in primary health care settings where there clearly is an increased demand for them. To date, most of the Australian literature about NPs has focussed on the implementation of the NP role and on overcoming the barriers to introducing these roles in acute care. More published papers discussing what these NPs are achieving and looking beyond the implementation phase of NP roles would be useful. Further research focussing on feedback from clients accessing NP services within primary health care settings would also be helpful.

5.14 Summary

This study highlights the significance of implementing NP roles in primary health care settings, as well as the additional scope that these roles can bring to small rural communities. It contributes to the knowledge of the NP working in primary health care settings by describing in detail what these roles look like and how they function within the context of primary health care settings. The case studies provided evidence of how integration works to deliver better health services within rural settings. The study provides evidence of the value of employing NPs in small rural towns to deliver mental health and drug and alcohol related services to complex clients and to work across a range of small rural hospitals and rural services to ensure that older people with complex psychogeriatric issues are managed effectively. Additionally, although these NPs were relatively new, they were both seen to be making considerable differences to the outcomes for small rural communities. The NP in Case Study 2 also demonstrated that the Nursing Practitioner impact is far greater, affecting not only the patients and their families, but results in reforming health care and changing practice and policy at local, state and national levels.

Chapter 6. Conclusion

This study provides a detailed account of the complexity and possible uniqueness of the NP role within a primary health care setting. The claim for uniqueness is based on the participants' rich accounts of why and how these roles were established and what impacts they have had on small rural communities. The successful implementation of the Nurse Practitioner (NP) roles into these communities shows what can be achieved when key stakeholders work together. The NPs themselves were fundamental to the success of the roles. They were highly experienced, mature, dedicated, driven, and passionate and respected senior clinicians with advanced knowledge and experience.

From my own conclusions about the NP role in primary health care settings, apart from the NPs themselves, the most admirable contributors who facilitated these positions were the senior nursing and non-nursing leaders in the Local Health District who challenged the way services were currently being provided and took a risk to have these NPs in place. At the time these NP positions were implemented, there was little evidence demonstrating the outcomes of NPs in Australia.

This research has provided evidence of the value of the NP role in the primary health care setting from a stakeholder perspective, but with some community and client input as well as client data. It has also provided evidence of stakeholder perceptions of the NP role that appear to have changed since the NP role was first implemented in Australia. The medical profession seems far less obstructive to working with the NPs, see the NPs as colleagues and peers, and have a very high level of respect for them.

There is also evidence of the Australian population now having an understanding of these roles, and their impact on small rural communities and individuals is understood. Stakeholders were supportive of the NP services. A number of key areas need to be addressed in Case Study 1. This includes the integration of the NPs with acute services to avoid conflict between teams and to promote communication and continuity of care. Identification of funding sources and resource allocation is important, as are team development, change management and established clinical governance structures. This will minimise risk and could prevent burn-out. Team development and education about how the NP service works are essential if the roles are to be successful. *"Stakeholder support is important if new health service delivery models are to succeed and to ensure that the model is acceptable and sustainable"* (Parker et al. 2012, p. 6). The NPs themselves generally felt supported in their role, but it is noteworthy that the NP in Case Study 1 did not see her colleagues in the formal Mental Health services or look for support from them.

Further recommendations for future national research into the NP role include:

- Studies in other small rural towns where Nurse Practitioners are leading services
- Quantitative analysis of client data for these services
- Descriptions of the Nurse Practitioner roles in published research to promote the Nurse Practitioner role in Australia.

The two NPs reviewed in this study showed that it is possible to have NPs working outside acute metropolitan hospitals and in a primary health care setting. What was common across both NP led services is that they were both providing an integrated service for complex patients. The service and care provided was patient-centred, according to the patients' needs, and holistic, meeting a wide range of needs. Both of the services ensure continuity of care, and both rely on good communication and the establishment and maintenance of good working relationships between clinicians, as well as established trust and rapport. Both of the NPs were able to achieve coordinated care management across providers and settings. The direct engagement of patients and ongoing support in the primary health care settings were seen as important. Both NP services engaged not only the patients but their families and carers.

The NP in Case Study 2 provided an excellent example of how an NP can function at a superior level. She not only gave expert advice to clients, their families and a range of clinicians, including medical, nursing and allied health, but also provided advice to policy developers at state and national levels. In this way NPs can establish inter-sectoral communication and service delivery, develop community participation and consultation, promote and maintain partnerships, and use policy and advocacy to change how health care is provided.

In terms of the wider applicability of this study to other rural settings senior managers need to be aware of the potential for NPs to contribute within their health services, identify communities most in need, champion the idea of a NP and develop local systems that enable services to work together including the private sector and government and non-government organisations.

In establishing a service, due consideration needs to be given to active policy development which specifies the target areas and client groups of the service, the referral processes and protocols, the model of formal clinical supervision, clinical governance procedures, direct line management structures and strategies to ensure that the NP is supported and does not become burnt out.

Leadership is an integral part of standards of practice for NPs. Both case studies provided valuable evidence of how leadership worked in practice within these two NP roles.

Health care planners need to be encouraged to recognise and actively consider the value of the NP in not only providing primary health care but taking the lead in integrating, adapting and delivering services. The NPs leadership ability working within multidisciplinary teams, integrating referral systems and collaborating and working in partnerships across services was a feature of this study.

The NP in the primary health care setting can provide a collaborative and innovative model of care to small rural communities and a community-based approach to how health care is provided to improve the provision of services in small rural communities.

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Appendices

Appendix 1. Human Research Ethics Committee approval documents and Site Specific Application approval documents

Appendix 1.1 Local Health District Human Research Ethics Committee Approval for Case Study 1

Health
NSW GOVERNMENT

28 September 2011

Professor Lesley Barclay
Director
University Centre for Rural Health, North Coast
PO Box 3074
LISMORE NSW 2480

Dear Professor Barclay

RE: [redacted]
An **evaluation of the** [redacted] **Project**

Thank you for your letter dated 26 September 2011 to the [redacted] Human Research Ethics Committee (HREC) in response to the Committees request for further information from its meeting held on 22 September 2011.

The Chair reviewed the information on 28 September 2011 and accepted the responses.

Final Low Risk ethics approval for a period of up to three years has now been granted for the above named study at [redacted]. The study **cannot commence** until the Site Specific Assessment (SSA) has been submitted to the relevant Local Research Governance Officer and governance approval granted.

The [redacted] HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (National Statement - 2007)*.

As part of this Low/Neglible Risk ethics approval, **the following must be provided** to the [redacted] HREC:

Amendments (including but not limited to updated protocols and Patient Information/Consent Forms) **and Reporting of Serious Adverse Events**

An amendment to extend the duration of ethics approval will be required should the study continue after five years from the approval date.

Researchers should immediately report anything to the Research Ethics Committee which might warrant review of ethical approval of the protocol, including:

- *Serious or unexpected adverse effects on* ***local*** *participants (reports to be de-identified);*
- *Proposed changes in the protocol or any other material given to the participants in the study must be known prior to being actioned, including patient information and consent forms; and*
- *Unforeseen events that might affect continued ethical acceptability of the project.*

Study Progress Reports

At least annually, reports from principal researchers should be submitted to the Research Ethics Committee on matters including:

Human Research Ethics Committee
[redacted]
Website [redacted]

- *Progress to date or outcome in the case of completed research;*
- *Maintenance and security of records;*
- *Compliance with the approved protocol;*
- *Compliance with any conditions of approval*
- *If the research project is discontinued before the expected date of completion*
- *Published abstracts/reports resulting from the research*

Upon completion of the research the HREC Completion form to be submitted to HREC

Please quote **HREC LNR015, short and full study name** in all correspondence and ensure all documentation relating to this study is forwarded, either two hard copies being **doublesided** and **2-hole punched,** to:

Research Ethics Officer
Human Research Ethics Committee
[redacted]

OR
Emailed to [redacted]health.nsw.gov.au

On behalf of the [redacted]HREC I wish you all the best with your research.

If you wish to discuss any matters further, please contact me on 02[redacted]

Yours sincerely

[redacted]
Research Ethics Officer
Human Research Ethics Committee

Frances Barraclough, Program Manager Clinical Education, UCRH NC

Appendix 1.2 Site Specific Approval for Case Study 1

Submission Code Date: 29/09/2011 18:12:07 HREC Reference: Online Form

Declaration by the Research Governance Officer (or other authorised person)

This declaration is not completed prior to submission of the application.

Project title:	An Evaluation of the [redacted] Project
Research Governance Officer jurisdiction:	[redacted] Local Health District [redacted]

The above project has been reviewed and has been granted site authorisation.

Officer's name [redacted] RGO. Authorised person

Position General Manager, [redacted]

Signature: [signature] **Date:** 27/10/11

Appendix 1.3 Participant Information Sheet for Case Study 1

Title of Project: An Evaluation of the [redacted] Project

PARTICIPANT INFORMATION SHEET

Invitation to participate
We are inviting you to take part in an evaluation study. This form explains why the study is being done and how you can contribute. Please take time to read the following information carefully. We encourage you to ask us if there is anything that is not clear or if you would like more information.

Purpose of the study
The purpose of the evaluation of the [redacted] is to:

- provide evidence of the effectiveness of the [redacted] model
- appraise the extent to which the model might be applied to other rural sites

Those most interested are f the funders of [redacted] Neighbourhood Centre, NSW Police Service, NSW Dept of Premier and Cabinet Office, and [redacted] Dept of Human Services – Community Services). This study will allow them to appraise the impact of the [redacted] disseminate the work of designing and implementing the model to a wider audience, and consider the further application of the model to other rural sites.

Why have you been invited to participate?
You have been invited to participate because you have experience or understanding of the project.

We will conduct up to three key informant interviews to enhance understanding and establish the relevant participants for a Stakeholder meeting.
We will hold a Stakeholder meeting, the purpose of which will be to:

- generate a shared narrative on the conception, birth and operation of the [redacted]
- understand what stakeholders were trying to achieve with the establishment of the [redacted] and what they consider this might look like i.e. how such achievements might be measured
- identify the key principles integral to the development and operation of the [redacted] which might be transferable to other rural contexts.

We will collect documentary evidence to assist with the activities listed above, including any health needs analyses which exist for the area, background documents describing the inception and development of the [redacted], Scope of Practice documents, existing annual reports or evaluations, evidence of costs etc.

The Stakeholder meeting will be accompanied by up to eight key subsequent informant interviews to clarify and explore themes and strengthen understanding, with a wider range of stakeholders. In addition, we propose to convene a focus group of [redacted], Community Health Nurses and Neighbourhood Centre Staff to elicit opinion of the impact of [redacted] on local services and the community.

Do you have to take part?
No, participation in this study is entirely voluntary. If you decide to participate, we would like you to sign a consent form. You may withdraw from the study at any time without giving a reason. Your withdrawal from the study will not influence your professional standing or the care of any of your patients/clients in any way.

What do I have to do?
This study uses face to face interviews and focus groups to collect information from you.

How will my privacy be respected?
The study's investigators are trained and highly experienced in health care and health care research. All the information you give us as part of this research project will be treated with the strictest confidence. Data from interviews will be stored separately from the names and the contact details of

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NORTH COAST
Excellence in education and research

the participants. Furthermore, any quotes in reporting will be anonymous. All electronic data will be held in a password protected and limited-access shared store.

What are the possible advantages/disadvantages of participating in this research?
You will help us understand the types of services and support that are needed when an innovative service delivery model is introduced to a rural locality. There are no foreseeable disadvantages of taking part.

What if I have concerns about this study?
The Study Investigators consist of senior researchers from the University Centre for Rural Health, North Coast. If you have a concern about any aspect of this study, you should speak to the Principal Investigator, Lesley Barclay who can be contacted on 6620 7570.

This study has been approved by the [redacted] Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact

Research Ethics Officer
[redacted] Human Research Ethics Committee
[redacted]
Email: [redacted].health.nsw.gov.au

and quote *Low Risk Application – An Evaluation of the* [redacted] *Project approved .....2011.*

What will happen to the results of the research study?
The findings of the study may inform the further development of the [redacted] project and contribute to discussion about the application of the model can be applied to other rural sites. You can obtain a copy of the study's report at the conclusion of the study. Data will be kept for 5 years after the results of this study have been published.

Who is organising and funding the research?
The study is funded by the NSW Department of Premier and Cabinet and will be conducted by the University Centre for Rural health, North Coast.

Who can I contact for more information?
Dr Jo Longman and Ms Frances Barraclough
University Centre for Rural Health
PO Box 3074
Lismore NSW 2480
Ph 6620 7570

Thank you for reading this information sheet and considering participating in this research.
Please keep this information sheet

Appendix 1.4 Participant Consent Form for Case Study 1

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NORTH COAST
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Consent Form

Title of Project: An Evaluation of the [redacted] Project

Name of Principal Investigators: Professor Lesley Barclay, Dr Jo Longman, Frances Barraclough, Dr Gao Yu

Please read this form. Please sign the consent form in the space provided below ONLY after the aims and process of the evaluation study have been fully explained to you and you have had an opportunity to ask questions.

- I voluntarily agree to take part in this study.
- I have read and understood the information sheet.
- I have been given the opportunity to ask questions and discuss the study with a member of the study team.
- I understand that my participation in this study will not directly influence my professional standing or the care of any of my patients/clients in any way.
- I authorise the investigators to disclose the results of my participation in the study but not any information that may identify me individually.
- I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published.
- I give permission for an interview with me to be audiotaped
- I understand that I can ask for further instructions or explanations at any time.
- I understand that I may be contacted again by the study team
- I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing. I also understand that withdrawing from the study will not affect my professional standing or the care of any of my patients/clients in any way.

Name:.....

Address. .....

Telephone number: .....

University Centre for Rural Health final version 31/8/2011

Signature: ..... **Date:** .....

For study personnel only

I confirm that the purpose of the study and what is involved has been fully explained to:

.....

I have given the above named a copy of this form together with the information sheet.

Investigators Signature: ..... **Name:**.....**Date:**.....

Appendix 1.5 Local Health District Human Research Ethics Committee Approval for Case Study 2

Health
[redacted]
Local Health District

Health
[redacted]
Local Health District

1 March 2013

Professor Lesley Barclay
University Centre Rural Health
PO Box 3074
Lismore NSW 2480

Dear Lesley

[redacted]HREC No: **LNR 058**

Project Title: **The Nurse Practitioner in a leadership role in the Primary Health Care Setting**

Thank you for your Low/Negligible Risk application to the [redacted]Human Research Ethics Committee (HREC).

Documentation received in relation to the above study was as follows:

- LNR NEAF – AU/6/4/131110 dated 13 February 2013
- Participant Information Sheet – Version 1 dated 11 February 2013
- Participant Consent Form – Version 1 dated 11 February 2013

The above documents were reviewed by the [redacted]HREC on 28 February 2013.

Final Low Risk ethics approval for a period of up to three years **has now been granted** for the above named study at [redacted]. The study **cannot commence** until the Site Specific Assessment/s (SSA/s) have been submitted to the relevant Local Research Governance Officer/s and governance authorisation granted.

The [redacted]HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (National Statement - 2007)*.

As part of this Low/Negligible Risk ethics approval, **the following must be provided** to the [redacted]HREC:

Amendments (including but not limited to updated protocols and Patient Information/Consent Forms) **and Reporting of Serious Adverse Events**

An amendment to extend the duration of ethics approval will be required should the study continue after three years from the approval 1 March 2013.

Researchers should immediately report anything to the Research Ethics Committee which might warrant review of ethical approval of the protocol, including;

- *Serious or unexpected adverse effects on **local** participants (reports to be de-identified);*
- *Proposed changes in the protocol or any other material given to the participants in the study must be known prior to being actioned, including patient information and consent forms; and*
- *Unforeseen events that might affect continued ethical acceptability of the project.*

Study Progress Reports

At least annually, reports from principal researchers should be submitted to the Research Ethics Committee on matters including;

- *Progress to date or outcome in the case of completed research;*
- *Maintenance and security of records;*
- *Compliance with the approved protocol;*
- *Compliance with any conditions of approval*
- *If the research project is discontinued before the expected date of completion*
- *Published abstracts/reports resulting from the research*

Upon completion of the research the HREC Completion form to be submitted to HREC

Researchers who are employees of [redacted] LHD or [redacted] LHD will require approval for publication from the respective Chief Executive. The approval form is available at: http://int[redacted]documents/view.php?documentid=497&status=a

Please quote **HREC No. LNR 058, short and full study name** in all correspondence and ensure all documentation relating to this study is forwarded, original with twelve copies (total 13) being **doublesided and 2-hole punched,** to:

Research **Ethics Officer**
[redacted] **Human Research Ethics Committee**
[redacted]

On behalf of the [redacted] HREC I wish you all the best with your research.

If you wish to discuss any matters further, please contact me on [redacted].

Yours sincerely

J. Holston
[redacted]
Research Ethics Officer
Human Research **Ethics Committee**

Appendix 1.6 Site Specific Approval for Case Study 2

NSW GOVERNMENT Health [redacted] Local Health District

23 September 2013

Prof Lesley Barclay
School of Public Health/Faculty of Medicine/University of Sydney
University Centre for Rural Health
PO Box 3074
Lismore NSW 2480

Dear Lesley

Ref Number: **G189**

Project Title: **The Nurse Practitioner in a leadership role in the Primary Health Care Setting**

Thank you for submitting an application for site authorisation for the above research project. I am pleased to inform you that authorisation has been granted for this project to take place at the following departments/sites:

- [redacted] LHD Nursing and Midwifery (Executive Director)
- [redacted] LHD Nursing and Midwifery (Nurse Practitioner)
- [redacted] Hospital/[redacted] Hospital (Geriatrician)
- [redacted] LHD Mental Health (Psychiatrist)
- [redacted] LHD Chronic & Primary Care (Manager)
- [redacted] Hospital (NUM [redacted])
- [redacted] Community Health (Manager)
- [redacted] Community Health [redacted] Manager)

The following documents / materials have been authorised for distribution at the above sites.

- SSA – AU/7/716318 dated 3 July 2013
- Participant Information Sheet – Version 1 dated 11 February 2013
- Participant Consent Form – Version 1 dated 11 February 2013

In addition, the following approved documents are acknowledged:

- [redacted] HREC Approval – dated 1 March 2013
- [redacted] NEAF – AU/6/4/131110 dated 13 February 2013
- RGO Correspondence Request for further information – dated 5 August 2013
- Response to RGO request for further information – dated 8 August 2013

Research Governance Office

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee (HREC) that granted ethical and scientific approval:

1. Governance Authorisation is granted for the interview component only of this study – as above.

   Authorisation for the observation component of this study ie: in a minimum of 4 settings eg: committee meetings, will be dependent upon the provision of evidence (to the [redacted] LHD Research Governance Officer (RGO)) of agreement/approval by the Chair/s of the relevant committee/s.

2. Recruitment of participants can only be conducted by those investigators listed under Q6 of the Site Specific Application and who have signed the Declaration of Researchers.

3. Proposed amendments to the research protocol or conduct of research which may affect the ethical or scientific acceptability of the application and are submitted to the approving HREC for review must be copied to the Research Governance Officer.

4. Proposed amendments which affect the ongoing authorised documents / materials for circulation at the sites listed above, or which alter the information submitted in your application for site authorisation. must be submitted to the Research Governance Officer.

If you wish to discuss the above, please do not hesitate to contact me on the numbers below.

Yours sincerely

J. Holston

[redacted]
Research Governance Officer

cc: Ms Frances Barraclough

Appendix 1.7 Participant Information Sheet for Case Study 2

Study Title: Nurse Practitioners Providing Leadership in the Primary Health Care Setting

PARTICIPANT INFORMATION SHEET

Invitation to participate
You are invited to take part in a research study. This form explains why the study is being done and how you can contribute. Please take time to read the following information carefully. We encourage you to ask us if there is anything that is not clear or if you would like more information.

Purpose of the study
The purpose of the project is to describe the leadership role of a Nurse Practitioner in a primary health care setting and to identify if and how this role has influenced policy and practice.

Why have you been invited to participate?
You have been invited to participate because you have experience working with, managing or implementing this NP role.

Do you have to take part?
No, participation in this study is entirely voluntary. If you decide to participate, we would like you to sign a consent form. You may withdraw from the study at any time without giving a reason. Your withdrawal from the study will not influence your professional standing or the care of any of your patients/clients in any way.

What do I have to do?
This study uses face to face or phone interviews and observation to collect information from you.

How will my privacy be respected?
The study's investigators are trained and highly experienced in health care and health care research. All the information you give us as part of this research project will be treated with the strictest confidence. Data from interviews will be stored separately from the names and the contact details of the participants. Furthermore, any quotes in reporting will be anonymous. All electronic data will be held in a password protected and limited-access shared store.

What are the possible advantages/disadvantages of participating in this research?
You will help us understand the impact of having a Nurse Practitioner in a rural primary health care setting. There are no foreseeable disadvantages of taking part.

What if I have concerns about this study?
The Study Investigators consist of senior researchers from the University Centre for Rural Health, North Coast. If you have a concern about any aspect of this study, you should speak to the Principal Investigator, Lesley Barclay who can be contacted on 6620 7570.

This study has been approved by the [redacted] Human Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact

Research Ethics Officer
[redacted] Human Research Ethics Committee
[redacted] health.nsw.gov.au

and quote *Low Risk Application ..... – Nurse Practitioners Providing Leadership in the Primary Health Care Setting approved .....*

What will happen to the results of the research study?
The findings of the study will report on the leadership contribution that a rural Nurse Practitioner can make in a primary health care setting and highlight the enablers and barriers that this NP experienced in influencing policy and practice at a local, state and national level. Data will be kept for 5 years after the results of this study have been published.

Who is organising and funding the research?
The study is being conducted by staff from the University Centre for Rural Health, North Coast.

Who can I contact for more information?
Dr Jo Longman and Ms Frances Barraclough
University Centre for Rural Health
PO Box 3074
Lismore NSW 2480
Ph 6620 7570

Thank you for reading this information sheet and considering participating in this research.
Please keep this information sheet

Appendix 1.8 Participant Consent Form for Case Study 2

Consent Form

Title of Project: Nurse Practitioners Providing Leadership in the Primary Health Care Setting

Name of Principal Investigators: Professor Lesley Barclay, Dr Jo Longman, Frances Barraclough,

Please read this form. Please sign the consent form in the space provided below ONLY after the aims and process of the study have been fully explained to you and you have had an opportunity to ask questions.

- I voluntarily agree to take part in this study and I have read and understood the participant information sheet.
- I have been given the opportunity to ask questions and discuss the study with a member of the study team.
- I understand that my participation in this study will not directly influence my professional standing or the care of any of my patients/clients in any way or the relationship I may have in future with [redacted] Services.
- I authorise the investigators to disclose the results of my participation in the study but not any information that may identify me individually. I understand that I can ask for further instructions or explanations at any time.
- I understand that information about me recorded during the study will be kept in a secure database. If data is transferred to others it will be made anonymous. Data will be kept for 5 years after the results of this study have been published.
- I give permission for an interview with me to be audiotaped
- I can lodge any concerns or complaints about the study by contacting the Research Ethics Officer

  Research Ethics Officer
  [redacted] Human Research Ethics Committee

  Email: [redacted]health.nsw.gov.au
- I understand that I may be contacted again by the study team
- I understand that I am free to withdraw from the study at any time, without having to give a reason for withdrawing. I also understand that withdrawing from the study will not affect my professional standing or the care of any of my patients/clients in any way.

Name:.....

Address: .....

Telephone number: .....

Signature: ..... **Date:** .....

For study personnel only

I confirm that the purpose of the study and what is involved has been fully explained to:

.....

I have given the above named a copy of this form together with the information sheet

Investigators Signature: ..... **Name:**.....**Date:**.....

Consent – Version 1 – 11/02/2013

Appendix 2. Interview Topic Guide for Individual Interviews for Case Study 1

Interview questions used in the one-on-one interviews

• Can you tell me about this service
• How did it come about?
• Why was it established?
• What did it aim to achieve?
• Why was there a need to change?
• What are its main functions?
• What was your role in implementing the Nurse Practitioner position?
• Do you think the model has been successful and how would you measure this?
  o What works well and what doesn't work so well – why?
  o Cost-effectiveness?
  o What would happen if the model ceased to exist tomorrow?
• How does the service compare with other Mental Health and/or Drug and Alcohol services in rural locations?
• How applicable is this model to other rural areas?

Appendix 3. Group Interview Guide for Case Study 1

Questions used in the group interview to generate discussion
Introductory statement: The aims of the group interview are to elicit an opinion of the impact of the mental health Nurse Practitioner service on local services and on the community.
1. Participant introductions • Can you tell us about your role and how long you have been in that role? 2. Mental Health Model • What is your understanding of the Mental Health Services Model? 3. Referrals • On what occasions do you refer patients to the Nurse Practitioner? • How often? • Can you give us some examples? • Who else do you refer these types of patients to? 4. Success of the model • Do you think the Nurse Practitioner model has been successful and how would you measure this? • What works well and why? • What doesn't work so well and why? • What was it like before the Nurse Practitioner was established? 5. Applying the model to other locations • How applicable is the Nurse Practitioner model to other rural locations?

Appendix 4. Interview Topic Guides for the Nurse Practitioner and other participants in Case Study 2

Questions asked of the Nurse Practitioner

- How would you describe your role as a Nurse Practitioner?
- How did your particular role come about?
- Has your role changed over time?
- How would others describe your role?
- How would you describe the leadership aspects of your role?
- What and/or who supports the effective functioning of your role?
- Which workplace and professional organisations at state and national government levels do you participate in?
- Has your role had any effect on policy or practice at local, state and national levels?
- What do you see as the main enablers for and barriers to being an effective leader in this role?
- Which stakeholders should I interview as part of this research?
- Do you have any suggestions for activities in which I can observe the Nurse Practitioner in a leadership role?

Questions asked of participants in Case Study 2

- Please describe the role of this Nurse Practitioner.
- Can you describe the history of the development of this Nurse Practitioner role?
- Were there any problems or issues when the role was first established?
- What is your role in relation to the Nurse Practitioner?
- Since the Nurse Practitioner role has been implemented, has anything changed?
- Has there been any impact on policy and practice of having a Nurse Practitioner?
    - At a local level
    - At a state level
    - At a national level
- What do you see as the main barriers to the Nurse Practitioner being an effective leader in this role?
- What do you see as the main enablers to the Nurse Practitioner being an effective leader in this role?

Appendix 5. Protocol for Direct Observation for Case Study 2

Please note this protocol was adapted from Creswell (2012).

Location (where)	
Date (when)	
Time	
Length of the activity (how long)	
Description of the activity, e.g. what was observed	
Description of participants: who are present?	
Description of the setting including the location and venue and the layout of the venue	
Descriptive Notes	**Reflective Notes**
Record descriptive as well as reflective notes about what one has seen, heard, experienced and thought about. For example, record what people say, including their facial expression and body language.	
Describe the impact if any that the Nurse Practitioner is having on this activity/event. Why is the Nurse Practitioner part of this group?	
Is the Nurse Practitioner relevant to this setting? What role does she have?	
Describe any unique features of the group or the activity.	

How are the participants reacting to the NP in this setting?	
Identify any factors that contribute to the successful delivery of the service provided by the Nurse Practitioner.	
Identify any factors that contribute to the unsuccessful delivery of the service provided by the Nurse Practitioner.	
Identify any times where the Nurse Practitioner challenged people/ideas/policies and practice	
Identify barriers to implementing an Nurse Practitioner in these settings, as well as barriers to ensuring the ongoing success of the service	
Comment on the organisational aspects that are needed to support this service/activity being observed	