Research paper

Contributions from the lifeworld: quality, caring and the general practice nurse

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ABSTRACT

Introduction Enhancing quality and safety in primary health systems is of central importance to funders, practitioners, policy makers and consumers. In this paper we explore the roles of general practice nurses in relation to quality and safety.

Method Cross-sectional multimethod study of 25 Australian general practices. Using rapid appraisal we collected data for each practice from interviews with practice nurses, general practitioners and practice managers; photographs of nurse-identified 'key workspaces'; structured observation of nurses for two one-hour sessions; and floor plans.

Results Quality was articulated in two domains, reflecting both external and intrinsic determinants. External determinants included a large number of essentially structural, procedural or regulatory processes, the most marked of these being practice accreditation and occupational health and safety;

these corresponded to the Habermasian idea of system. Intrinsic determinants related mostly to nurse perception of their own quality behaviour, and consisted of ways and means to improve or optimise patient care; these correspond to Habermas' notion of the lifeworld.

Discussion Nurses describe a productive tension between the regulatory roles that they play in general practices, and patient-focused care, contrary to Habermas' suggestion that system subsumes lifeworld. Current funding systems often fail to recognise the importance of the particular elements of nurse contributions to quality and safety in primary care.

Keywords: general practice, Habermas, nursing, primary health care, quality and safety

How this fits in with quality in primary care

What do we know?
Nurses have an important role in quality and safety in hospitals.

What does this paper add?
General practice nurses have important roles in quality and safety in two areas – system-support work, usually directed by the practice, including accreditation, occupational health and safety, and infection control, and those created by themselves in relation to patient-centred care. The patient-centred focus of nurses is underestimated by general practitioners, and under-supported by current funding streams.

Introduction

Quality and safety are key performance domains of a health system, and are of primary importance to funders, practitioners, policy makers and consumers. In Australia, the Australian Commission on Safety and Quality in Health Care (an intergovernmental commission) has developed a national strategic framework to improve safety and quality across the entire Australian healthcare system.[1] Nurses have an established role as quality and safety wardens in hospital,[2,3] but how or if these activities are also undertaken in the small general practice setting is as yet unknown.

Quality in Australian general practice is underpinned by the standards for general practice promulgated by the Royal Australian College of General Practitioners (RACGP), now in their third edition.[4] These standards cover all aspects of general practice, from patient records and appointments to processes such as sterilisation, compliance drug regulations, restricted substances, and occupational health and safety (OH&S) requirements. Practices choose to be assessed against the standards every three years by one of two private companies (Australian General Practice Accreditation Limited and General Practice Accreditation Limited). This voluntary practice-accreditation process has been in place for only eight years and is one of the most significant changes to general practice recently.

Developing in tandem with practice accreditation, and integrated with the process, has been a change in the structure of general practice, particularly an increase in the number of practice nurses. Driven by practice needs and government incentives, nurse numbers have increased from 4924 in 2005 to 7824 in 2007. Fifty-eight per cent of general practices now employ at least one practice nurse.[5] Nurses now have more complex, flexible and strategic roles within practices,[6] and exist within a structure supported by external agencies, such as the divisions of general practice network.[7]

Discussion about the overall contribution of nurses to quality and safety is complex because of a lack of definition of the roles that nurses perform,[8] and intercountry variation in the roles of practice nurses. In jurisdictions such as the UK, where general practice nurses have a longer history and wider clinical involvement, they have become responsible for the provision and quality of significant aspects of clinical care.[9] Other jurisdictions devolve all clinical care upon the physician, delegating only administrative tasks to nurses.[10] The advent of electronic communication technologies has also changed nurse– (and doctor–) patient interactions,[11] with a resultant impact on perceptions and expectations. An additional analytical problem is the fact that nurses rarely work in isolation, but are part of a 'practice team' that in itself is capable of influencing the quality of care.[12]

In this paper we explore the roles of general practice nurses in relation to quality and safety. We argue that there is a productive tension between the regulatory roles that nurses are required to play in general practices, and the creation of quality through 'communicative action', which focuses on the patient's experience. The latter emphasises inter-subjectivity and the moral dimension of patient care. In framing this argument, we draw on two Habermasian concepts: communicative versus strategic action, and system versus lifeworld.

Lifeworld is a term first used in a phenomenological description of human society by Husserl,[13] and subsequently modified by Habermas.[14] It is the stock of skills, competencies and knowledge that ordinary members of society use in order to negotiate their way through everyday life, to interact with other people and ultimately to create and maintain social relationships.[14] Lifeworld denotes a moral consciousness, and recognition of the variety of subjective experiences and the inherent conflict that can arise between those subjective experiences, enacted through communicative action. It contrasts with the *system*, which Habermas describes as a rules-governed element, usually representing either the economy or the state.[15] Systems are enacted through rational, purposive or strategic actions. Such a theory is an effective way of explaining the tensions that arise in complex areas of human endeavour, such as health interactions.[16,17]

These concepts allow us to interpret these interactions and communications in a way that leads to

increased understanding of how individuals interpret, perceive and reconcile differing influences on their behaviour. Individuals, in Habermas' terms, have cognitive interests, those concerns that allow them to understand and shape their physical and social world.[18]

Method

Study design

We undertook a cross-sectional multimethod study of 25 general practices. The sampling frame included practices from rural and urban settings, including small and large staff numbers, nurse- and doctor-predominant practices, with corporate, state (public) and private ownership models. All practices were visited for one day by a trained researcher who did not have a background in general practice.

Data collection

To maximise the data gathered, while minimising impact on the practice, we used a rapid appraisal technique. Rapid appraisal was developed by rural sociologists,[19] and is most commonly now used by field epidemiologists to investigate disease outbreaks.[20] We collected interviews with practice nurses ($n = 36$), general practitioners (GPs) ($n = 24$) and practice managers ($n = 22$); photographs of nurse-identified 'key workspaces'; structured observation of nurses for two one-hour periods (totalling 51 hours of observation of 34 nurses); floor plans; and situational analyses. Interviews were semi-structured, and addressed (for nurses) work history, types of work done in general practice, contribution to safety and quality, and their experiences within the workplace, and (for doctors and practice managers) the experiences of the general practice with nurses, roles of nurses and contribution to safety and quality. All interviews were audiotaped and transcribed. The rapid appraisal tool was piloted in two practices with each researcher and an independent observer; concordance rates for the observational component were 94% and 96%.

Analysis

A coding framework was developed in an emergent fashion, by undertaking case analyses for each practice. The coding framework was then used to establish themes for an inter-case analysis across practices, and was applied to interviews, pictograms developed from observation data, floor plans and photographs. All data were entered into NVivo 7.0 (QSR International).

The analytical team included nurses, GPs, a social scientist and a policy adviser. Data were analysed by the team working in collaboration through an iterative process using the constant comparison method.[21]

Results

Details of participating practices are presented in Table 1. Interview subjects articulated quality in two domains, reflecting external determinants and intrinsic determinants. External determinants included a large number of essentially structural, procedural or regulatory processes, predominantly practice accreditation and occupational health and safety. Intrinsic determinants related mostly to nurses' perceptions of their own quality behaviour, and consisted of ways and means to improve or optimise clinical processes and outcomes.

There appeared in the interviews to be considerable dysjunction between these two. The first category was characterised by tasks and activities, often allocated to nurses by their employers or colleagues, to meet regulatory needs, and these had clearly defined protocols and outcomes. The second category related to nurses' own constructions of quality, based on professional ideals and their personal relationships with patients.

When we combined interview data (what was said) and observational data (what was done), nurses were found to have a more intuitive and less formalised role than that mentioned by other staff – roles achieved by nurses themselves rather than ascribed by others. Nurses were able to combine structured quality improvement activities like accreditation with more patient-centred, subjective caring activities. The elements particularly derived from the observational data and floor plans that support quality care by nurses include: being able to access all parts of the general practice; being centrally located within the practice; being invested with continuity of personal care, especially when many doctors worked part-time; and having relative freedom over disposal decisions about their time.

External drivers for safety and quality: the system

> 'Well, I always think that like, with accreditation, and all of the OH&S standards and all that, it's really: is it a practice I feel safe working in? And is it a practice my staff are safe working in? And is it a practice that the patients are safe in? You know, we have children, toddlers, old people, so you know, obviously the sharps things are up on the brackets.' (doctor, practice 22)

Table 1 Characteristics of participating practices

Practice	Profile			
	Location	GPs	Nurses	Business structure
1	Rural	5	2	Private
2	Regional	4	2	Private
3	Metropolitan	8	3	Private
4	Rural	2	3	Private
5	Metropolitan	9	4	Private
6	Rural	13	6	Private
7	Rural	7	4	Private
8	Rural	6	7	Public/state community health centre
9	Metropolitan	12	3	Private
10	Regional	4	1	University medical centre
11	Rural	8	6	Private
12	Metro	3	1	Private
13	Metro	17	5	Corporate
14	Regional	8	3	Private
15	Rural	1	2	Solo GP
16	Metro	12	2	Private
17	Metro	8	1	Private
18	Rural	4	2	Private
19	Remote	2	2	Private
20	Metro	7	2	Private
21	Rural	3	5	Private + experimental collaborative model with state partners
22	Regional	4	5	Private
23	Rural	1	1	Solo GP
24	Rural	6	6	Private
25	Metro	5	5	Private

Accreditation

Nurses were almost universally seen to be either key players or drivers of accreditation for general practices. In small practices, nurses were often tasked with organising or arranging accreditation. In larger practices this role was often ceded to practice managers, with nurses being given the responsibility of ensuring that relevant protocols were in place, and clinical standards, such as sterilisation, were met. Usually this worked as a collaborative process, but the need for a specific clinical skill set was recognised.

> 'Accreditation wouldn't be there without the nurses. Again, the things that sound very simple like sterilisation of instruments, well if you don't have the nurses to ... that's one of their areas. That's a huge area even for a well-trained nurse. I can't imagine doing it without a nurse.' (staff, practice 3)

Nurses developed an autonomous and authoritative role within the practice when it came to accreditation, having great freedom to change practice organisation and a 'policeman' role to ensure that the relevant standards were met on the day.

> 'A large role, yeah, because I'm the one responsible for infection control and sterilisation, that's a major part of accreditation. I'm also the girl with the big stick that goes around and says you have to do this and you have to do that [laughs].' (nurse, practice 16)

This role was reinforced by the workspace allocation of the nurses, which was usually in a relatively public space (when compared to the doctor in a consulting room) and close to the work elements of stores and sterilisers. Nurses' propensity for systems and procedures often manifested in them taking on a key role in developing manuals and protocols for accreditation. Their organisational orientation contributed to a focus on implementing and operationalising guidelines and requirements.

> 'Very important because, as I said, our practice nurse is a person that is involved in systems and changing systems and as I also hinted she's the one who possibly implemented this – you know, from what is actually suggested from policy to a procedure, to actually implementing that to make sure that doctors do that. She's very useful in doing that, like making sure people put in the recalls and reminders and take off the recalls and reminders when they have done it and things like that, like, you know. So I think yeah, the practice nurse position ... our practice nurse contribution to the team is invaluable ... it's not like she's the only one that runs the whole accreditation, but her contribution to it is really invaluable.' (doctor, practice 2)

Occupational health and safety

Many OH&S issues were related to accreditation, but the emphasis on OH&S often extended beyond the immediate needs of that process to wider application within the practice. In a few practices, nurses demonstrated particular leadership around OH&S. In most practices, the ethos was one of shared responsibility, with much of this falling to or being taken up by practice managers. Nurses seemed to acquire this role because of a combination of their clinical knowledge and their flexibility (of both time and physical situation) within the practice structure.

Many nurses articulated a detailed understanding of OH&S, with repeated references to nominated OH&S representatives and communication processes, including risk notification and staff meetings. Nurses were sometimes responsible for all the organisational aspects of OH&S, from becoming familiar with the relevant legislation and requirements, to organising the protocol and ensuring adherence to it.

> 'Right, well Danni is our occupational health and safety rep and she's done quite a bit of training and she's quite good at pointing out things as health hazards.' (nurse, practice 21)

The three main types of OH&S activities that tended to be undertaken by nurses were: management of equipment and supplies; education and raising the awareness of others and operating as a knowledge base or 'go to' person; and monitoring and modifying the behaviour of others.

> 'That's a constant red alert. I'm constantly watching what people do and where people leave things and making sure they put them in the right containers and that's my role.' (nurse, practice 6)

Cardiopulmonary resuscitation, emergency care and triage were mentioned by nurses in the context of OH&S, but probably related more to patient safety. This may also reflect the clinical emphasis of these issues, their linkage to the practice accreditation process, and the tendency of nurses to be generally 'safety conscious' on behalf of others. When asked to indicate their key workspaces, most nurses photographed both the treatment room and a 'backstage' room dedicated to safety: the locked drugs cupboard, the steriliser room, or storage sites for soiled equipment. Workplace ergonomics and safety relating to buildings and other structures tended to be part of the practice managers' role.

Practice protocols and clinical education

The presence of the nurse, particularly those that were always in the practice, corresponded with a perception of an extra clinical level of patient safety, again highlighting the issues of the flexibility of nurse time and the relative physical availability of the practice nurse (compared to GPs).

> 'Oh definitely it takes the stress off the doctors. It takes the stress off the other staff members. Patients are much better when they've got a nurse dealing with them. The safety issues, much better having a nurse here than relying on staff to learn CPR [cardiopulmonary resuscitation] and that we know we have a qualified person, even over lunchtimes there is always someone here.' (manager, practice 6)

In ascribing roles to nurses, or allowing nurses to attain roles for themselves, practices were clearly changing how they structured patient care in a way that enhanced their ability to provide quality and safety to the patients. Nurses were increasingly allocated, or took on, responsibility for the development of clinical protocols and education associated with these. This was particularly noticeable for areas targeted by the government incentives, e.g. immunisation, and wound management, but often extended beyond those areas. In contrast to doctors who were fixed to their consulting

schedule, nurses appeared to have the flexibility of time to develop and implement changes within the practice, and served as a bridge between the medical staff and the administrative staff.

> 'Two of the nurses went to a burns talk last Tuesday night ... came back with new information. I've already typed up the new procedures and they're in place. I've spoken to each GP individually, told them we're not to do it this way we're to do it that way, and they've all come on board. So we've changed already.' (nurse, practice 5)

In this example, system-level protocols that were used to define nurses activities also gave them the power and licence to change patient management and staff behaviour.

Patient context: the lifeworld

The preceding section applied to structural elements that nurses often felt were mandated for them by their employment relationships or the regulatory requirements of the general practice environment. Nurses distinguished this from a personal construction of quality exemplified by their relationship, and effects of their activities, with their patients.

> 'I mean the first priority is your patient, that they are getting good care, that they are getting followed up ... I mean with other occ health and safety issues, staff have to be safe as well but you know, patient really is number one in my opinion anyway.' (nurse, practice 23)

Nurses often describes a sense of fulfilment when a patient recovered or survived well. Despite the 'busyness' that was apparent in the observations, nurses reported that providing patients with the time they needed, and helping with the 'little things' that 'make a difference' was a key source of satisfaction. If absolute outcomes were beyond reach, then the satisfaction of offering comfort or support sufficed. Demonstrations of trust by patients, as well as expressions of gratitude and positive feedback were strong contributors to 'good days'. Continuity and the ability to build on relationships with patients, both over time and within the patient's context – their lifeworld – were appreciated.

A common issue raised by nurses was the desire to have sufficient time to ensure that their patient care and clinical work was creating or maintaining quality. Some nurses articulated this through statements about the importance of spending time with patients.

> '... sometimes it's hard to fit that time in but sometimes you just have to. Just have to stop and listen.' (nurse, practice 3)

Other nurses conveyed this desire through expressions of frustration or dissatisfaction of not having sufficient time to spend with patients or 'do things properly':

> 'A really bad day at work, I think to me a really bad day at work will be too many patients. It's when it's one of those days where everybody turns up, there are no spare appointments, they just keep being slotted in, and you're not giving people the amount of time that you would like to get yourself.' (nurse, practice 21)

... or conversely, the satisfaction for having sufficient time, such as:

> 'Oh a great day where everything goes smoothly. I've got the time to write things up properly, I've got the time to ring patients back properly ...' (nurse, practice 9)

Such examples reinforced nurses' perceptions and prioritisation of quality. Nurses appeared to demonstrate 'softer' perceptions of quality that involved activities such as chatting, listening, and spending time with patients. In the activity analyses it was possible to see how nurses rapidly cycled between tasks, often maintaining several patient-related tasks at once, while not allowing the system issues to predominate.

Time and quality

A primary determinant of whether nurses were able to achieve their desired level of 'quality' in delivering care was the availability of time. Doctors and managers also articulated a discourse around time and the creation and maintenance of quality. However, this was generally expressed in terms of time management across the practice, whereas nurses saw their own time management as central. Doctors and managers tended to express time and quality issues in a more managerial context than nurses, who often highlighted related issues of personal satisfaction.

A common point raised in the data, particularly by doctors and managers, was that nurses had time to create or maintain quality, whereas doctors did not. This was often articulated through examples of nurses picking up the 'quality' slack by performing tasks that doctors did not have time for, and which improved the quality of service of the practice as a whole. These tasks include spending more time with patients, conducting minor procedures on patients, and performing other duties, particularly those relating to accreditation and OH&S.

One of the reasons that nurses may have been allocated the role of picking up the 'quality' slack was the relative value of different people's time. Statements such as 'patients don't want to waste the doctor's time' (manager, practice 16) and 'nurses can afford to spend a little bit more time with the patients than what we can' (doctor, practice 13) suggested an apparent lack

of demand for the nurses' time, and implied that it was valued less than the doctors'. The frequency of claims from nurses that they were extremely and sometimes excessively busy, and the observational support for this, suggested that the key issue was the relative value of time rather than availability. These differences in perspectives of time management may be an example of time valuing within a practice; if the doctors' time was seen as the most valuable, it seems likely that other staff members would be required to adjust their own scheduling to accommodate the scarce time resources of the doctors. This may explain why doctors in particular frequently discussed time management in practice terms, as they are able to call on other people's ('less valuable') time resources to complement their own overscheduled work patterns. Nurses, on the other hand, generally only highlighted their own time management because they have no 'less valuable' time resources to call upon.

Discussion

Nurses in general practice inhabit two worlds of quality and safety. One is the system view, the perspective that is taken by professional organisations and government institutions. Grounded in the management theory of continuous quality improvement, this world is dominated by protocols and external reference points. This perspective is the one articulated by the other members of the practice team, and is recognised by the nurses themselves. This systems approach has some similarities to the 'system' articulated by Habermas as 'the self-regulating system whose imperatives override the consciousness of the members integrated into them',[14] and nurse actions in this regard are interpretable as strategic actions, being responsive to system issues rather than influencing them.

Alongside this system view is the nurses' own construction of quality as manifest in the care that they provide to their patients, and the representations of what it is that makes a 'good day' or a 'bad day' in their management of patients. In this regard they are creating a Habermasian view of their workplace, as they reconcile their lifeworld with the system they inhabit. They are driven by both the rules of their hierarchy and their own construction of quality. That nurses' time is considered 'less valuable' than doctors', but also important to system quality, raises questions about the perception and prioritisation of quality by doctors.

Nurses in general practice simultaneously exhibit strategic action in their contributions to the systemic elements of the practice, while undertaking communicative action with their patients. For Habermas, a

necessary tension existed between system and lifeworld, with system threatening to overwhelm lifeworld; if this occurred, a 'pathological social form' would emerge. This theory was located at the level of the state or economy. For the nurses in our study operating at the micro-organisational level, the tension between system and lifeworld was not conceived as a battle. Rather, the nurses constantly negotiated their work between these two equally important contexts for quality.

We noted that there was, in some practices, a limit to the strategic action that was undertaken by nurses to improve quality. Intra-practice hierarchies may constrain the types of strategic action nurses can undertake. Some nurses described themselves as improving the practice by stealth, through influencing the most junior doctors and hoping for a 'trickle-up' effect, or by leaving laminated notes in work areas about washing hands or disposing of sharps.

Importantly, the lifeworld approach, which encapsulates many of the key domains of quality, is often under-appreciated by the agents of the system, the organisations and managers. The GPs in our study repeatedly discussed that the single most important contribution of the nurse was in the systems areas, especially accreditation. As a rule, the medical literature around quality care frequently focuses on 'system'-level interventions. In the nursing literature on caring, the dominant theoretical framework is phenomenology, so it is unsurprising that the nursing literature frequently calls on phenomenology and Habermas' lifeworld to explain the intense experience of intersubjectivity that nurses report with patients.[22] Whereas Habermas spoke of the colonisation of the lifeworld by the system, in this case we see that the nurses inhabit a system, but colonise that system with their creation of the lifeworld.[15] Without a definitive role with historical precedent, the system issues (accreditation, employment conditions) have formed the basis of nurse activity, yet within that nurses are creating a quality practice that is of their own devising.

There were two exceptions to this contention that nurses productively negotiate system and lifeworld (see Box 1). In practice A, the physical space, fixed practice hierarchy and an external contractual obligation all combined to create a role for nurses that was primarily systems focused. All staff in this practice described themselves as overworked, and too busy for patient-centred medicine. In practice B, the nurse in question, as a result of a firm and directive personality, had negotiated that the practice employ an assistant, although in interview a doctor in the practice repeatedly emphasised these tasks – no longer performed by the nurse – over the actual patient care performed by the nurse. In practice C, the autonomy of the nurse was underpinned by an independent salary arrangement and a collegiate approach to interprofessional activity in the practice. Structural issues (funding and

Box 1 Examples of system and lifeworld negotiations in general practice

System dominates lifeworld: practice A

This was the only practice in which the nurse did not identify patient care as her primary role, but rather infection control. In this medium-sized practice with 2.5 full-time equivalent nurses, doctors supervised most nursing work, but there was little structured communication (e.g. meetings) between them. This was exacerbated by the physical structure of the service, where nurses' rooms were separated from doctors' rooms. The nurses' section was specifically designed so that nurses did not have contact with patients in the waiting room, and there was little corridor contact with other health professionals. The practice had contractual relationships with a nearby industry, which required doctors to be on 24-hour alert, and the nurses to prioritise the needs of the industry. The nurses described their clinical work in technical terms (wound management, immunisation, taking blood pressures).

Lifeworld dominates system: practice B

This was an established city practice where the practice nurse had worked for over a decade. The practice had two nurses, and one nursing assistant, who undertook some of the traditional 'system management' work such as sterilising, stocking, and infection control. The senior practice nurse spent most of her time doing complex care planning and patient support work, often through home visits. She described herself as being careful to police boundaries so that she did not end up doing work that she did not view as her core nursing work, which could be delegated to receptionists or done by doctors themselves.

Lifeworld melds with system: practice C

The best example of alignment of system and lifeworld was a practice where the nurse was the primary employee of a university health service, and was salaried by the university rather than out-of-service income. She was the manager of the service, and had sat on interview panels for the doctors in the service. She undertook health promotion around the university campus, as well as counselling and supporting individual students.

interpersonal relationships) and freedom to make decisions about time use seem to be important enablers of the kind of quality nurses can bring to general practice.

This study has shown that nurses are integral to safety and quality in general practice. One of the features of their work is fluidity, that is, the capacity to bind the practice together into a quality context. Nurses seem to be positioned to help introduce and drive change. Given the importance of system issues in past policy development, public policy should ideally recognise the nurse's role in an effective, safe primary care system. Current funding systems often fail to recognise the importance of nurses' contributions to quality and safety in primary care. Task-based Medicare funding, as is the case currently, drives nurses towards task-based activities, with loss of unstructured time. Excessive focus by organisational managers on accreditation and OH&S as nursing roles may also lead to nurses spending more time on paperwork than with patients. Both of these approaches may limit the breadth of both the system and lifeworld contributions that nurses can make to quality and safety.

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ETHICS

This study was approved by the Royal Australian College of General Practitioners National Research and Evaluation Ethics Committee.

CONFLICTS OF INTEREST

None.

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