Supporting teams integrating a PHCNP

Professionals' capacity to develop effective and satisfactory clinical practices depends primarily on the energy, openness, and mutual trust of the clinicians themselves. Yet it is important not to underestimate the key role played by managers, by nursing and medical directors, and by administrative assistants in supporting practice and its development. This information sheet addresses the support systems for primary care teams integrating PHCNPs.

Defining support for practice

The literature identifies three complementary spheres of activity needed to adequately support primary care teams integrating PHCNPs. The first involves clinical support and focuses on developing and supporting PHCNPs' practice. The second has to do with the team and is aimed at developing a comprehensive and consensual practice model. The third encompasses the healthcare system as a whole, whose aim is to promote the development and optimization of patient care and to support the integration of PHCNPs into the healthcare system. Figure 1 illustrates these team needs, dividing them into three complementary spheres. Each sphere is described in detail in the following sections.

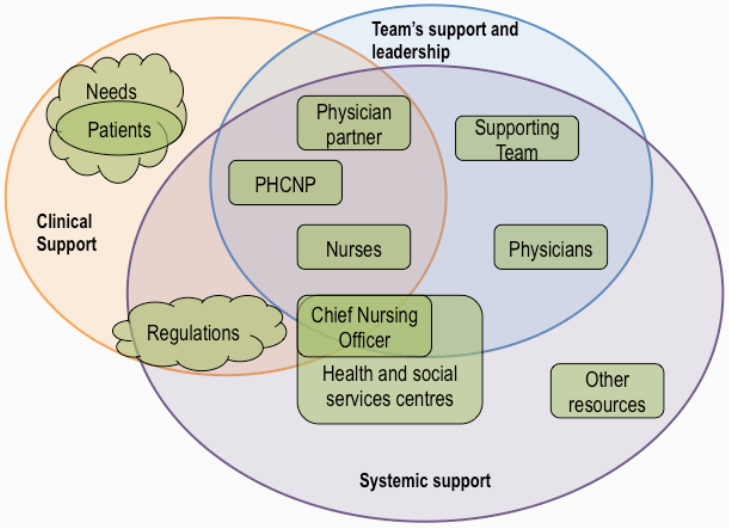

Figure 1: The three spheres of support for teams

Source and validity of these recommendations

The information presented here comes from two sources: 1) the results of a systematic review of the scientific literature on advanced nursing practice in primary care, and 2) the results of six case studies of settings that have integrated PHCNPs in three health regions of Quebec. Details of the methodologies used for each of these two research efforts are presented in the Methodology section at www.phcnp.info. The analyses of the data produced in each of these two components were used to inform each other reciprocally. Thus, the data from the scientific literature were analyzed in relation to the various models of integrating PHCNP practice found in Quebec, while the empirical data were interpreted based on themes identified in the literature.

The nature of management and leadership practices needed to support clinical teams makes it difficult to analyze the effectiveness of these practices without taking into account the influence of the professional, organizational, and regulatory contexts. The recommendations proposed here incorporate the management practices most frequently associated with the development and strengthening of effective clinical practices. In this regard, there is strong consensus in the literature that appropriate support for teams is a key determinant of successful PHCNP implementation. However, the same literature does not offer much in the way of concrete recommendations on how this support should be provided. The research team applied their combined expertise in organizational analysis and in management to broaden the knowledge base used to suggest some more instrumental possibilities.

Three spheres of support for teams

First, it should be noted that the deployment plan for primary care PHCNPs calls for integrating them into very different clinical settings. Thus, depending on each case, PHCNPs could work in private clinics, community health settings, or hospitals. The administrative complexity, resources available, management responsibilities, and support processes will vary considerably depending on the setting. This information sheet has deliberately been generically designed to be applicable to different cases regardless of practice setting characteristics.

Moreover, while it is useful to divide the discussion on team support into three spheres here, it is important to remember they are interdependent and, in practice, necessarily integrated.

Clinical support

The objective of the first sphere, which we refer to here as clinical support, is to support PHCNPs in their clinical practice with patients, which is the most important dimension of the PHCNP's role. This includes physical, mental, familial, and social assessment of the patient, as well as the development and management of a treatment plan, in collaboration with the interprofessional team.

Prescribing authority and decisional autonomy are two determinants of full deployment of the PHCNP's role. The data from our studies coincide with the findings from experiences in other provinces and countries showing that some PHCNP are not able to fully deploy their roles. PHCNPs encounter practical problems related to drug prescriptions, diagnostic testing, and getting back consultation reports. These problems are sometimes caused by administrative failures and sometimes by the opposition of certain professionals who do not have a good understanding of this role. The support provided to PHCNPs should help smooth out these difficulties. PHCNPs need to be supported in negotiations on both levels, clinical and systemic, especially with care partners, so they can exercise their full scope of practice. Follow-up is required to resolve any problems they may encounter; we will return to this point later.

To optimize PHCNPs' potential, they also need to be able to develop their clinical judgment and decisional autonomy and apply these in practice. These are competencies that develop over time

and depend on the quality of interprofessional collaboration (see the Collaboration section at www.phcnp.info) and on the comprehensiveness of the patient management model (see the Patient management section at www.phcnp.info). Likewise, access to continuing education is an important factor in developing a good quality clinical practice, not only for PHCNPs, but also for physicians and other professionals. There is no consensus on the number of hours of continuing education required to support PHCNPs' practice, but the literature identifies the lack of availability of specific training, difficulties in being liberated from work, and distance to training locations as significant obstacles. Access to online training programs might be a viable solution.

The empirical data gathered in the cases showed great variability in the deployment of the PHCNP's role. In those settings where the PHCNPs' scope of practice was most extensive and where their role definition was evolving, several determining factors were observed: joint meetings among managers, nursing or medical directors, and partner physicians; a shared vision of the PCHNP's role; mobilization of the care team members' complementary expertise; and collaborative work with nurse clinicians. The PHCNPs' prescribing authority and decisional autonomy was also discussed and clarified by the whole team, including the medical team.

Support for the team

There is solid evidence in the literature that strong leadership and consistent support to primary care teams fosters the emergence of an effective patient management model (see the Patient Management section at www.phcnp.info). The data from our cases confirm this idea. Our case analyses also showed great variability in the administrative structures in place and in the practitioners mobilized (e.g. clinic managers; head nurse; licensed practical nurses; physician clinic manager; manager, etc.). Only rarely were there clear lines of authority delineating the responsibilities of managers at different hierarchical levels. According to the literature, the characteristics of primary care teams (small professional groups, very autonomous participants, centralized power in terms of operations) favour informal functioning and structures that are not very hierarchical. This type of structure produces good results when there is a consensual vision of the organization's goals and values. There needs to be positive leadership from one or more key persons who together have strong legitimacy and a clear sense of purpose. Conversely, in such structures there is an inherent risk that suboptimal work processes might take hold and that no one would feel accountable for resolving problems.

Effective communication mechanisms are a key factor in encouraging the emergence and maintenance of a shared vision of the team's objectives and values. Communication must be balanced between formal mechanisms (team meetings, thematic discussions, leaders assigned for each issue) and informal opportunities for exchange. When a PHCNP is introduced into the team, some people, regardless of their function within the organization, should be prepared to take on a boundary spanning role between the medical and nursing disciplines. Here again, there is no solid evidence for any specific operationalization, but several credible data sources suggest that the principle itself is important.

Similarly, a balance is required between direct communications (such as discussions between two professionals to improve a suboptimal work practice) and indirect communications (such as transmitting suggestions for improvement to the person in charge of a specific file). Whether the direct or indirect approach is more appropriate will depend on the people involved, the subject, and the context. In any change process, it is normal that tensions and differences in preferences would arise. In some cases, tensions are best resolved by face to face discussion. Resolving disagreements directly within the team is part of the process of creating team dynamics. Even so, it is essential to be able to consult a neutral third party when necessary. A determining factor appears to be support provided by a person whose mandate is to preserve an overall vision of all the work processes, the patient management model, and the team's goals. One of the very few articles that deal specifically with management models needed to support the introduction of a PHCNP describes such a perspective as viewing things from a higher vantage point, as opposed to becoming absorbed in the daily demands: "...an effective managerial strategy is to observe the team as if the manager is looking from a balcony" (Reay, Golden-Biddle & Germann 2003 p.402). Here again, there may be several options for how this function is attributed. What is important is that the team is able to count on someone who has the legitimacy, capacity, and motivation to take on this role. In this respect, even though officially in Quebec the PHCNP reports directly to the nursing department, our results showed considerable variability in Chief Nursing Officers' level of involvement. Some Chief Nursing Officers seemed reluctant to interfere in the activities of the clinical settings. It would probably be helpful to have a collective reflection on the roles played and support provided to care teams by the various departments involved, in different provinces and organizations.

Lastly, best practices in leadership and support to teams are characterized by, on one hand, the existence of several possible channels of communication that can be easily used as needed, and on the other, the active involvement of managers and directors who exercise active leadership to support change. Other fundamental principles include communication mechanisms that are available to all team members and an interdisciplinary team vision. Finally, when team meetings are not limited only to physicians but also include the PHCNP, this fosters integration and, more broadly, contributes to the development of an optimal practice.

Systemic support

Beyond their internal functioning, primary care teams are also part of larger healthcare systems. As such, the operations of primary care teams are also structured by the environments in which they practice, with regard to such things as billing policies, enrolment of new patients, rules governing waiting lists for patients without a family physician, or referrals for tests or specialized services. As with any other practice change, the introduction of a PHCNP entails adjustments and communications between the primary care team and its external environment. This is the third sphere of support in the model presented here. However, the PHCNP role is relatively new, and part of that role is played out at the interface between medicine and nursing. To fulfil their responsibilities, PHCNPs must be able to rely on collaboration from other actors in the external

environment (specialist physicians, diagnostic services, pharmacists). This is why the systemic support sphere is particularly important when integrating a PHCNP into a care team.

In Quebec's current PHCNP deployment plan, for example, regional and local implementation committees have been mandated to develop a communications plan to ensure that diagnostic services, pharmacists, and other health and social services centre (CSSS) resources are aware of the arrival of a PHCNP. These communications are also meant to explain the PHCNP's field of practice and the procedures in effect. Still, even when such a plan is developed and implemented, practical difficulties are to be expected. It is therefore important that clinical teams be given the systemic support needed to identify appropriate solutions and to ensure problems are resolved. Some of these problems may be local, while others may be at the regional or provincial levels. The persons in charge of systemic support must therefore work hand in hand with the different decision-makers involved.

Quebec's deployment plan attributes a central role to the Chief Nursing Officer. But regardless of who is assigned to this support role, fulfilling this mandate takes time and a good knowledge of the local environment. This is why, in practice, the functions of direct supervision and systemic support may need to be shared among the local leaders.

Throughout these three spheres, it is important to consider support as being a response to the needs of all clinical teams, so that they can establish and put into practice new and more effective practice models. The arrival of PHCNPs is not a problem that entails additional work, but rather a part of the solution to the problems in our healthcare system.

For more information:

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