

# Nurse satisfaction with working in a nurse led primary care walk-in centre: an Australian experience.

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## KEY WORDS

Walk-in centre, nurse led, nursing autonomy, advanced nursing roles, primary care

## ABSTRACT

### Objective

The aim of this study was to gain insight into the nursing staff's experiences and satisfaction with working at the ACT nurse led Walk-in Centre.

### Design and Setting

Interviews with nursing staff working at the ACT Walk-in Centre were informed by a phenomenological approach. Questions were developed within inter, extra and intra-personal variables of satisfaction, underpinned by the principles of role theory.

### Subjects

Twelve nurses were interviewed; three nurse practitioners and nine advanced practice nurses. Their ages ranged from 31 to 63 years and they had a minimum of 15 years of nursing experience. Interviews ranged from 30 minutes to two hours duration.

### Results

Walk-in Centre nurses' satisfaction with a number of inter and extra-personal factors was associated with their previous education and experience (intra-personal factors). Role stressors included adapting to autonomy, role incongruity and lack of access to appropriate education, training and sources of collaboration and mentorship. Sources of satisfaction were the autonomous role, relationships with the team and the capacity to deliver quality nursing care.

### Conclusion

Whilst autonomy is valued by nurses, this does not translate to isolation or independence. Autonomy is only a source of satisfaction when coupled with supportive and cohesive professional relationships with both nursing and medical colleagues. Organisations implementing advanced nursing roles must have a comprehensive understanding of the requirements of nursing autonomy to ensure effective role implementation and associated job satisfaction. These findings add impetus to the need for the development of nursing education programs tailored specifically to primary health care.

## INTRODUCTION

New and innovative models of primary health care, including extended roles for nurses, are being introduced internationally in response to workforce shortages and subsequent diminished access to health care. Evidence has established that nurses can provide primary health care of a quality equal to that of doctors in terms of cost, use of resources and health outcomes (Desborough, Forrest et al 2011; Laurant et al 2005; Horrocks et al 2002; Venning et al 2000).

Nurse-led walk-in centres have been implemented extensively throughout the United Kingdom (UK) and recently introduced in the Australian Capital Territory (ACT), Australia. In the ACT a walk-in centre is defined as 'non-residential facility operated by the Territory for the treatment and care for people with minor illness or injury' (ACT Health 2010). The ACT nurse-led primary care Walk-in Centre was modelled on the Walk-in Centres in the UK. It is open from 0700 to 2300 hours seven days per week and is staffed solely by nurse practitioners and advanced practice nurses, who provide care for minor illnesses and injuries in accordance with clinical protocols. Appointments are not required, as the name suggests, patients can just walk in. In the first year of operation, approximately 1,100 patients were seen each month at the Walk-in Centre (Parker et al 2011). On opening, funding for the walk-in centre was ongoing.

In Australia nurse practitioners work autonomously and collaboratively in advanced and extended roles. They are educated to masters level (Gardner et al 2009) and the role includes the legislated capacity to prescribe medications and order diagnostic tests (ACT Health 2010). Advanced practice nurses in the Walk-in Centre have extensive knowledge and experience in the specific field of practice (Australian Nursing Federation 2009); however have no prescribing rights or capacity to order diagnostic tests.

These two levels of registered nurse have different requirements for the implementation of their roles. In the Walk-in Centre context, Advanced Practice Nurses work in accordance with pre-defined Walk-In Centre clinical protocols and are clinically responsible to nurse practitioners. In the ACT, nurse practitioners work in accordance with Clinical Practice Guidelines (CPGs). These provide a framework which guides the practitioners' autonomous practice through describing areas of clinical practice, functions of the role and referral processes (Desborough 2011). CPGs complement the nurse practitioners' defined scope of practice and if not already in place, must be developed within the first three months following recruitment to a position (ACT Health 2008). Operationally, all these nurses are responsible to the Assistant Director of Nursing.

The Australian Primary Health Care Research Institute (APHCRI) at the Australian National University (ANU) conducted an independent evaluation of the first twelve months of operation of the walk-in centre (Parker et al 2011). This paper reports on semi-structured interviews conducted with nurses at the Walk-in Centre conducted as part of this evaluation.

### **Nurse satisfaction**

National and international literature is rich with research regarding nurse job satisfaction in the acute care sector (Hayes et al 2010; Dunn et al 2005; Bucknell and Thomas 1996; Blegen 1993; Gray-Toft and Anderson 1981). However, nurse job satisfaction in primary care and in particular, with working in nurse-led roles and in Walk-in Centres has only been observed in the UK National Health Service (NHS) (Rosen and Mountford 2002).

Understanding nurses' experiences and job satisfaction in the ACT Walk-in Centre is important in terms of this role as a new and attractive clinical career pathway for experienced nurses in Australia and its subsequent value as a retention strategy.

When higher levels of nurse job satisfaction are experienced, there is an increase in morale and commitment which makes it more likely a nurse will stay in the profession (Newman et al 2001). Nurse satisfaction is vital

for the provision of quality nursing care and subsequent patient outcomes (Bohannon-Reed et al 1983), for organisational commitment, the avoidance of staff absenteeism, turnover and workplace conflict (Cavanagh and Coffin 1992). Increasing job stress is associated with decreasing satisfaction amongst nurses (Blegen 1993).

Hayes et al (2010) identified three variables essential to nurse satisfaction; inter-personal, extra-personal and intra-personal. Inter-personal factors relate to interactions between the nurse and others. They include autonomy, direct patient care, professional relationships and educational opportunities. Extra-personal factors are those beyond a nurse's direct interactions with others and are influenced by institutional or governmental policies: pay, organisational policies such as the use of clinical protocols, routinisation and organisational constraints. Intra-personal factors refer to the characteristics nurses bring to the workplace: individual coping strategies, age and education (Hayes et al 2010).

A secondary influence on the nature of enquiry and analysis of data regarding nursing satisfaction in the Walk-in Centre is the fact that this is a new and innovative nursing role. The ways in which nurses transitioned to, and negotiated challenges to this role, and sources of role stress were of interest in this study; that is, what works and what doesn't work in the role (Handy 1993).

## **METHODS**

### **Aim**

The aim of this study was to gain insight into the nursing staff's experiences and satisfaction with working at the ACT Health nurse led Walk-in Centre.

### **Design**

The methods were informed by a phenomenological approach; concerned with the study of experience from the perspective of the individual, their lived experience, and subjective analysis of that experience (Liamputtong and Ezzy 2005). This approach was considered the most appropriate to gain the nurses' perspectives. However, whilst pure phenomenology begins from a point free from preconceptions (Lester 1999), this study followed more recent approaches, clarifying the researchers' subjective views and including theoretical influences on the approach to interviews and their interpretation (Plummer 1983; Stanley and Wise 1993). The researchers were very much subjective actors in this study, adapting interviews iteratively in response to participants' experiences and emphasis on areas of concern. Regular team meetings facilitated this approach.

### **Theoretical framework**

Hayes inter-personal, extra-personal and intra-personal variables (Hayes et al 2010) are consistent with other research on nurse satisfaction (Cortese 2007; Curtis 2007; Dunn et al 2005) and were considered suitable as a foundation for this study. Along with this, the principles of role theory (Handy 1993) informed the design of the semi-structured interviews and data analysis.

### **Sample**

The sample was purposively chosen to include all nursing staff who had been employed at the ACT Health Walk-in Centre during its first year of operation. This included one staff member who had resigned from the centre prior to the evaluation.

### **Recruitment**

All clinical nursing staff who had worked at the Walk-in Centre at the time of the independent evaluation (n=13) were invited to participate in this project; three nurse practitioners and 10 advanced practice nurses. Information about the project and participation was sent to nursing staff via email, addresses for whom were

supplied by Walk-in Centre management. This direct approach from the researchers was a deliberate attempt to avoid a recruitment approach through management, which might be perceived to exert pressure on staff to participate. Staff willing to participate contacted the research team via email or telephone to arrange a time and date to participate.

### **Data collection**

Participation comprised a face-to-face interview, prior to which, participants were required to sign a consent form. The interviews took place in February 2011, at various times and locations determined as convenient to participants, with consideration made for privacy.

Interviews were conducted by three members of the research team and were audio-recorded and transcribed verbatim.

### **Data analysis**

Interviews were transcribed by a transcribing service, and identifying information about the participants removed. NVivo 8 software (QSR International Pty Ltd., Melbourne, Australia) was used to manage the data and facilitate coding. Transcripts were analysed by one of the researchers, with a focus on identifying ideas, concepts and patterns, the way in which they fell within identified intra, extra and interpersonal variables and comparison for similarities, relationships and tensions (Braun and Clarke 2006). Analysis and interpretation was discussed with the other researchers at regular team meetings.

### **Ethical considerations**

Ethics approval to interview the nursing staff at the ACT Health Walk-in Centre was received from The ACT Health Human Research Ethics Committee (ETHLR.10.407) and subsequently given expedited approval by The Australian National University Human Research Ethics Committee (protocol no. 2010/649).

### **Rigour**

Research rigour was enhanced through respondent validation and regular team discussions (Barbour 2001). Transcripts were emailed to all participants for their perusal and comment prior to data analysis. Coding and analysis of the dataset was discussed at team meetings to ensure thoroughness of data interrogation and to discuss insights into data interpretation.

## **RESULTS**

Twelve nurses agreed to participate: three nurse practitioners and nine advanced practice nurses. Their ages ranged from 31 to 63 years and they each had a minimum of 15 years of nursing experience. Interviews ranged from 30 minutes to two hours duration.

A number of themes emerged, most of which fell within the inter-personal and extra-personal variables. The intra-personal variable seemed to relate mostly to how the nurses education and experience influenced their perception within the other two variables. Within each variable areas of satisfaction and sources of stress were described.

### **Inter-personal factors**

#### ***Team relationships provided support***

All participants identified their nursing colleagues as their primary source of support, collaboration and mentorship. These relationships were seen to sustain them throughout their initial transition to practice in the Walk-in Centre, which many found difficult.

Respondent 8: *...we had good teambuilding in the beginning and that allowed for really strong team support.*

**The challenge of autonomy**

Autonomy was identified as a challenge by most advanced practice nurses, who mostly stated they had adapted to over time. The responsibility of completing an episode of care autonomously through to sending a patient home was identified as a particular source of role stress for advanced practice nurses.

Respondent 4: *The whole autonomous practice has been the hardest thing. Not having someone there to back you up. Not having someone there to ask ... not having a senior medical person, like a doctor, to consult with. That's the biggest change.*

Nurse practitioners were more comfortable with autonomy, but expressed a desire for a source of on-going consultation and collaboration, which had been available to them in previous positions.

Respondent 1: *I think that I would have a [doctor] involved for consultative processes. They don't have to be on-site but to have somebody to call, to have that kind of relationship, to bounce things off.*

**Clinical protocols limited capacity to deliver quality care**

Participants were satisfied with the time and resources available for them to deliver quality nursing care. At the same time this capacity was perceived to be limited by the requirement for them to deliver care in accordance with clinical protocols. A number of participants stated that they had the knowledge, education and experience which armed them with a far greater scope of practice than that provided by the protocols. Enhancing these protocols was identified as a measure which would improve satisfaction in this area.

Respondent 7: *We're limited obviously, because of our protocols [but] I think the quality that we give is awesome.*

The nurse practitioners described particular frustration in regard to this. They felt they were prevented from working to their full scope of practice through delays in the development of CPGs.

Respondent 1: *The other thing that was frustrating was that they kept on delaying, unofficially delaying the CPGs development...*

They were often required to refer patients to other health providers, when they could easily have managed themselves if their CPGs were in place.

**Relationships with medical staff**

Relationships with the medical staff at the nearby emergency department was important to participants. Protocols requiring the nurses to contact doctors with issues that were either un-resolvable by telephone or inappropriate for referral were a source of frustration for both the nurses and doctors.

Respondent 11: *I think there were times we were required to send patients because of our [protocol] to Emergency, and the Admitting Officers didn't feel it was appropriate and so they'd get a little bit stroppy and we'd say well I agree with you, we don't really particularly feel it's necessary but we don't have a choice. So that was embarrassing I guess and probably made them a bit stroppy.*

Some of these issues had been resolved, through changes to protocols, whilst other issues had been managed through development of new approaches and a consolidation of relationships between medical and Walk-in Centre staff.

Participants only contact with general practitioners was through the referral of patients to them; they did not have any direct professional dealings. However the advent of referrals from GPs was perceived as a sign of support.

Respondent 5: *We haven't had many dealings with GPs except that what is great is that they are referring in to our clinic now and so if they can't see a patient they recommend, and it's a minor thing, so to me that's, barriers are breaking down.*

### Extra-personal factors

#### ***Training and on-going education was inadequate***

All participants strongly expressed their belief the preparatory training for their role in the Walk-in Centre was inadequate.

Respondent 9: *Touched on information. I sort of felt that it needed to go a lot more in-depth.*

This belief extended to a perceived gap in training for new employees, whose training was largely comprised of informal arrangements with existing staff in the centre as opposed to participating in a formal training program.

Respondent 12: *My biggest issue is there's no clear-cut training guidelines for new staff...*

A number of participants expressed frustration with the difficulty in accessing study leave due to the absence of relief staff, and at times the availability of education in-services that were not appropriate to their clinical needs.

### Intra-personal factors

#### ***Nurses' qualifications were associated with satisfaction with autonomy***

There was great variety in both levels of experience and education of the nursing staff. All but three had tertiary level post-basic nursing qualifications, three were currently studying towards graduate degrees and one towards a certificate qualification. There was a direct association between this variable and participants' experiences of autonomy within the new role. Increased education and experience were associated with satisfaction and autonomy, yet at the same time dissatisfaction associated with a desire to utilise a broader scope of practice, and a desire for a medical source of clinical advice and mentorship. The opposite was observed for nurses with less education, training and experience.

## DISCUSSION

Similar to the nurses in our study, NHS walk-in centre nurses' confidence with autonomy reflected the degree to which they had previously been practising this way (Rosen and Mountford 2002). Our findings that those with higher levels of education and experience were more comfortable and satisfied with autonomy might imply a link between educational preparation and critical thinking, as suggested by Zurmehly (2008), who also identified this link as important in terms of registered nurse job satisfaction (Zurmehly 2008).

The Advanced Practice Nurses' satisfaction reflects the provision of adequate supports for the implementation of their roles at the Walk-in Centre, including clinical protocols and collaboration and mentorship with nurse practitioners. However, implementation of the Walk-in Centre nurse practitioner roles was not supported. Similar to evidence from previous research (Gardner et al 2009), a significant barrier to implementation was the delay in development and approval of CPGs, the timely implementation of which is known to optimise nurse practitioner role implementation (Desborough 2011). Secondary, was the absence of a source of clinical collaboration and mentorship, a known enabler to the implementation of nurse practitioner roles (Desborough 2011; ACT Health 2007).

Previous research has highlighted the influence of leadership styles and support for the implementation of new nursing innovations (Eckhardt Wilson 1989). Mentorship could be of benefit to nurse practitioners in the implementation of their Walk-In Centre roles. The benefits of mentorship are well documented and include improved nurse satisfaction, clinical competence and empowerment (Mills et al 2005). These benefits also extend to patients, whose outcomes and satisfaction are also enhanced (Mills et al 2005). Literature regarding mentoring tends to focus on novice nurses (Beecroft et al 2006; Smith et al 2001), rather than more experienced nurses. Another area of nursing innovation in Australia is the development of practice

nurse (PN) roles. Mentoring for PNs was found to be important for role development and implementation; however dependant on organisational support and infrastructure (Smith et al 2001). Mills et al believe that acknowledgment of the role of clinical supervision for nurses in Australia is lagging behind other countries (Mills et al 2005). The experience of the nurse practitioners at the ACT Walk-In Centre highlights the importance of clinical supervision and its implementation to support these innovative roles.

In the absence of a source of clinical advice and mentorship, autonomy can be a source of role stress. This finding raises the question, What does professional autonomy in nursing mean and what are the requirements of this? Holland Wade (1999) states that one critical element of professional nurse autonomy is intercollegial interdependence (Holland Wade 1999). Whilst autonomy is valued by nurses, this does not translate to isolation or independence. Autonomy is only a source of satisfaction when coupled with supportive and cohesive professional relationships with both nursing and medical colleagues. The Walk-in Centre nurses were very clear on their defined scope of practice and sought out a source of advice and mentorship when dealing with clinical issues at the boundaries of this scope of practice.

Common to all participants' satisfaction were barriers to access on-going education and role ambiguity. Meeting the training needs of nurses with diverse education and experience was found to be a significant challenge for managers of Walk-in Centres in the United Kingdom (Rosen and Mountford 2002; Salisbury et al 2002). This raises the need for inter-sectoral collaboration to ensure that parallel with health sector reforms which expand roles for nurses in primary health care, is the development of nursing graduate capacity to match these reforms (Desborough et al 2011; Keleher et al 2010).

Sources of satisfaction common to both groups were the ability to provide quality nursing care, a manageable workload and relationships within the team. The description of a cohesive and supportive team was significant to their satisfaction levels; in fact teamwork and professional relationships are as important to nurse job satisfaction as autonomy (Cortese 2007; Dunn et al 2005).

Previous research indicates that a combination of factors impact nurses' overall level of satisfaction or dissatisfaction in the workplace (Hayes et al 2010). Our research indicates that some aspects of nurse job satisfaction are closely tied to intra-personal factors, specifically previous education and experience.

## LIMITATIONS

Some intra-personal factors were not examined in this study; affectivity, behavioural disengagement and positive reframing are coping strategies that have been associated with nurse job satisfaction (Hayes et al 2010). The research team did not feel qualified to explore these factors with the nurses at the walk-in centre, and with already quite lengthy interviews, this would have added considerable time and complexity.

Pay, an extra-personal factor, was not raised in the interviews, which was an oversight of the research team. This might have been due to an assumption that the staff was happy with their pay, as this staff is paid at the highest level available to nurses in the ACT. The results are limited due to this omission.

## CONCLUSION

Nurse-led walk-in centres provide an opportunity to improve access to primary health care; however integral to their success is the considered implementation of nursing roles. Examination of nurses' experiences of transitioning to and working in advanced roles at the ACT Health Walk-in Centre and their associated satisfaction highlights issues that influence nurse job satisfaction in this role.

The Walk-in Centre nurses' job satisfaction was strongly influenced by their experience of the autonomous

role, having implications for organisations implementing these roles. A comprehensive understanding of what autonomy means for nurses is essential. Once an understanding of autonomy is established, the requirements of autonomous nursing roles need to be met. These include the provision of relevant and adequate education and training, and an avenue to work to one's full scope of practice supported through access to clinical mentorship and collaboration. This is essential for both nurse satisfaction and the outcomes for patients accessing these services.

Provision of education and training presents a challenge to health care services, considering the variety of backgrounds and experience of nurses working in Walk-in Centres. These findings add to the impetus in Australia for the development of nursing education programs at a tertiary level, specific to primary health care.

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