Final evaluation report for Primary Care Practice Assistant Demonstration Programme

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Participating organisations

Comprehensive Care Ltd in association with Waitemata PHO

Comprehensive Health Ltd, in association with Waitemata PHO, is a leading primary care organisation in the area of innovation within the sector to improve population health and exploring new models of care in general practice.

Unitec Institute of Technology

Unitec Institute of Technology educates people for work, in work and through work with a portfolio of programmes extending from certificates and diplomas through to degrees and doctorates, across a wide range of professional and vocational areas.

Their dual-sector commitment to postgraduate and degree-level study on the one hand, and to vocational education and training provides work ready graduates with professional and vocational skills.

AUT University

Faculty of Health & Environmental Sciences

Work placements in public and private hospitals, clinics and community settings reinforce students’ skills and knowledge and provide students with the required number of practical hours to meet certification requirements and industry standards.

Their programmes are designed in close liaison with district health boards and primary health organisations to ensure graduates achieve personal success and meet the growing needs of their future employers.

Health Workforce New Zealand

HWNZ leads and co-ordinates the planning and development of the country's health and disability workforce. They support demonstration sites that test the development of new workforce roles, new and extended scopes of practice and new models of care. They have funded this demonstration.
Acknowledgements to the Clinical Governance Group

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Jane Matavesi  Student and Pasifica Representative
Carol Ngawati  Māori in Tertiary Education Representative

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Executive summary

Background
The current primary care sector is under pressure to address the needs of a growing, ageing and diverse workforce. Younger medical practitioners look for a work-life balance different from previous generations, and the rise of a model of primary health care using contract workers has changed the delivery of primary care services. The role of a Primary Care Practice Assistant (PCPA) was developed to reduce the pressure of non-clinical and simple clinical tasks on general practitioner and nursing staff and to support front desk and administration staff. Increasing the efficiency of a practice to allow practice staff to work to the top of their professional competency would enhance the quality of health care provision. Health Workforce NZ (HWNZ) with Comprehensive Health Ltd (Waitemata PHO) contracted the development of an academic and practice-based learning programme with Unitec Institute of Technology and Auckland University of Technology (AUT) as a demonstration programme. The PCPA educational programme was designed to include training in clinical and administration tasks in conjunction with one level 4 and three level 5 academic health-related papers focusing on a practice-based health care worker course and a PCPA course as well as on communication skills, human development and environmental influences on health outcomes.

Nineteen employees from 13 practices in Auckland and Northland trained as PCPAs over three semesters in 2012 and 2013.

Aim of the innovation
The aim was to provide a trained flexible workforce to work in any aspect of a general practice with stable and predictable patients under the direction and delegation of the range of professionally trained staff.

The key objectives
To create a programme to develop the role through work-based learning and a tertiary level academic programme and to demonstrate the value of the role across a variety of general practices.

Methodology
The evaluation contained both qualitative and quantitative information. A qualitative research design was the most appropriate approach to examine the experiences of a range of primary health workers and the patients they served. Quantitative analysis of measurable data gave information on the cost benefits of employing a PCPA and where rankings provided information able to be quantified. A range of data collecting methodologies were utilised including surveys, interviews (both face to face and by telephone), analysis of course curriculum documents, international and national literature and analyses of financial and other consequences of employing a PCPA in a practice.

All PCPAs and a sample of 10 practice nurses, 10 practice managers and 10 GPs were interviewed at least once over the period of the evaluation. One hundred and seventy four of 180 invited patients across 12 practices completed satisfaction surveys.

Key findings
Cost benefits
Most utilisation of the PCPA role was in freeing up practice nurses to run independent clinics and meeting health targets. The greatest financial benefit was freeing up a GP to see more patients per hour or to allow time for the GP to follow special interests.
Patients
Patients reported high levels of satisfaction with the role. They appreciated the different level of care the PCPAs provided, the reduced waiting time and that consultations with GPs were more focused with PCPAs carrying out basic recording prior to a consultation. Patient understanding of the scope of the role was limited to their own interactions with a PCPA.

Primary care practice assistants
All PCPAs completed the competency requirements for the skills and tasks required and have completed the academic course requirements and were highly positive about their role in their practice. Four PCPAs are enrolling in a nursing degree in the future and other PCPAs have identified ongoing education they would like to pursue. The flexibility of the PCPA role allowed practices to utilise the strengths of individual PCPAs and to meet specific practice needs.

A time analysis showed that most of the PCPA time was working under delegation from nurses.

General practitioners
General practitioners reported that with having to do less paperwork their quality of life had improved; they had time to see more patients, to follow up their special interests, after hours administration was reduced and they had happier staff. Additional services included the ability to see more patients per hour, and time to pursue special interests such as minor surgery, skin clinics or an interest in ophthalmology. The attachment of a PCPA to a GP was the most financially beneficial.

Practice nurses
The nurses reported being able to work to the top of their profession and to have time to initiate more patient education and to increase nurse-led clinics. In addition, they had uninterrupted time, because a PCPA was able to attend to the nurse telephone, contact patients for recall, chaperone, and assist GPs with minor surgery. Job satisfaction increased and PNs valued the support from the project manager/clinical co-ordinator.

Practice managers
Practice managers reported little personal job relief except when a PCPA had a high level of experience and skills and was scheduled to provide regular assistance. PMs were positive about the flexibility of PCPAs to be allocated tasks across a practice and reported that the practice staff was more integrated. They were very positive about the release of nursing time to conduct independent clinics and to increase the scope of patient education and health checks.

Limitations
The evidence in this evaluation is limited by timing constraints to conclude data collection before the programme had ended, limited access to financial practice information and the difficulty of attributing financial changes to any one staff member.

Conclusions
The value of the role of a primary care practice assistant has been well accepted by staff and patients and has shown value in all the practices in the programme. A trained PCPA provides opportunities for general practitioners and registered nurses to be innovative in their practise and to work to the highest level of their professional capacity.

The programme has been extremely successful with several practices intending to increase the number of PCPAs they employ. Interest in the continuation of the programme is strong, both from practice staff in the demonstration programme and public response to advertised positions. The intention of all practices in the demonstration programme to continue and extend their employment of PCPAs in the future is a strong indication of the value for money they have experienced. Patient satisfaction has been high.

1 Note: The full results for semester 3 were not available for this report.
The flexibility of the programme ensured the autonomy of practices to utilise the role as they deemed appropriate. The use of a PCPA was variable in scope with some PCPAs working mostly in reception or administration, some were attached to nurses entirely or mostly and a small number were mostly attached to a general practitioner. This flexibility meant that there was no ‘ideal’ role configuration but because the role was used to meet the needs of each particular practice, satisfaction was high among them all.

Critical strengths of the programme’s success have been the employment of a project manager/clinical coordinator who had experience in primary care and clinical teaching to ensure ongoing support for the PCPA through the academic programme and practice visiting to ensure standardisation of in-practice training and support. The commitment of at least one general practitioner and one senior practice nurse in each practice to provide in-practice supervision and training of delegated tasks has also been important.

As most of the PCPAs had already been employed in their respective practices, there were no issues of support and trust among staff. Financial support for training was variable with practice commitment ranging from a paid full day a week to a part payment for study days. Some practices required return of service for this commitment. During the demonstration programme the course fees have been paid by HWNZ.

All PCPAs worked under the principles of direction and delegation set out by the Nursing Council of NZ Guidelines to ensure that health consumers’ needs are met by the appropriate healthcare professional/personnel. PCPAs need to work only with stable and predictable patients. However, the full scope of the usefulness of the role has not been evaluated as the evaluation was completed before the programme ended. None of the PCPAs were working for a full week.

The programme across two institutions provided a comprehensive course but was logistically and educationally not ideal.

**Recommendations**

1. There is universal satisfaction with the role of a Primary Care Practice Assistant and it is recommended that the training programme is continued and expanded nationally.

2. The programme needs to be further developed within one organisation to be accessible throughout New Zealand and flexible with blended delivery to meet the needs of rural and distance learning.

3. The programme needs to be submitted to the New Zealand Qualifications Authority to ensure that it provides opportunities for developing a career pathway and to provide entry to a student loans scheme.

4. That a job description, practice policies and protocols be developed to define the role and function of a PCPA, while retaining the flexibility currently inherent in the role that has allowed each practice to best utilise the role.

5. The provision of a session on the requirements for safe direction and delegation as outlined by the Nursing Council needs to be available for all practice staff in a mentoring position for trainee PCPAs.

6. Future programmes need to retain the in-practice teaching components with students and staff supported by a clinical co-ordinator.

7. A preparatory block course to introduce students to academic writing, referencing, Endnote and Medline would assist students in tertiary education for the first time.

8. Dedicated opportunities through the course for supervised practice of new clinical skills need to be available to standardise competency.
Introduction and background

The role of a Primary Care Practice Assistant (PCPA)\(^2\)

The current primary care workforce is under pressure to be able to address the needs of a growing, ageing and diverse workforce. Younger medical practitioners look for a work-life balance different from previous generations and the rise of a model of primary health care around the employment of contract workers has changed the delivery of primary care health services.

In order to reduce the pressure of non-clinical tasks and simple routine clinical tasks on general practitioner and nursing staff workloads and to support front desk and administration staff, the role of a Primary Care Practice Assistant (PCPA) was developed. Increasing the efficiency of a practice to allow practice staff to work to the top of their professional competency would enhance the quality of health care provision. Health Workforce NZ (HWNZ) in association with Comprehensive Health Ltd (Waitemata PHO) contracted the development of an academic-practice based learning programme with Unitec Institute of Technology and Auckland University of Technology (AUT) to provide a demonstration programme. Thus the PCPA educational programme was designed to include training in clinical and administration tasks with level 4 and 5 academic health-related papers focusing on a practice-based Health Care Worker course and a PCPA course as well as on communication, human development and environmental influences on health outcomes. The underpinning focus was to provide a flexible workforce which is under the direction and delegation of the range of professionally trained staff in aspects of a general practice.

A comprehensive recruitment process in the Waitemata area including emails to all practices with information regarding the innovation, followed by personal contact with practice managers or practices nurses in each practice, was followed by contact with ProCare and practices on the North Shore and in West Auckland. Finally Manaia PHO practices were contacted by the Manaia PHO and those interested were visited by the project manager. Over 170 practices were contacted, culminating in the involvement of 19 PCPAs in 13 practices. The majority of PCPAs had been already employed in a practice, mostly in reception and administration. When a position was advertised, there was considerable interest from all over New Zealand.

The training programme spanned 18 months, during which 19 PCPAs were employed in the practices in Auckland and Northland for a minimum of 20 hours a week and released for study one day a week during three semesters over 2012 and 2013. During the time in practice a designated practice nurse was required to take responsibility for mentoring the student. At all times the student was to work under the direction and delegation of a doctor, practice nurse or practice manager. Practices had the freedom to structure the use of PCPA time and tasks to suit their staffing requirements, but needed to ensure that the specific generic skills taught in the teaching programme had been accomplished\(^3\).

There is evidence in literature that a role to assist health professionals has been utilised in a number of practice settings under a variety of names such as health care assistant, medical assistant and practice assistant. In many instances this role has been focused on only one aspect of assistance. The difference in the role of the PCPA is that the training is practice wide - and provides flexibility for primary health care providers to utilise the PCPA in ways to fit with the dynamics of any particular setting. In addition, the role provides a conduit between the different parts of the health care team.

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2 For the purpose of this evaluation the title of PCPA will be used throughout. However, other descriptors were used in some practices.

3 Practices were able to opt out of this requirement if a particular skill was performed only by registered staff in that practice.
International concerns which had been expressed about the introduction of such a role were similar to those expressed when the role of primary health care practice nurses expanded to include more extensive and autonomous use of their clinical skills. The evidence in the literature review (see Appendix 1, page 50) and expressed in this evaluation has shown that these concerns have not been confirmed.

**Educational programme for PCPA training**

The PCPA demonstration training programme was designed to provide a mixture of academic courses to provide a clinical and administrative base of knowledge and practice, and work based experience to consolidate and improve upon the class-based training. The academic component of the training comprises four courses;

- Health Care Worker course provided by Unitec NZ (level 4).
- NUR S504 Primary Care Assistants Course A & B provided by Unitec NZ.
- 555101 Life Span Development and Communication provided by AUT University.
- 555401 Health and Environment provided by AUT University.

The four courses attended by the PCPAs taught the basic skills outlined in the PCPA job description, in conjunction with on-the-job training to consolidate this knowledge. The way in which each practice chose to utilise their PCPA influenced how much the PCPA used and built on the skills learnt.

**Health Care Worker Course (HWC)**

The generic HCW course (from Unitec) was a generic course for students wanting to work in a variety of health care settings, and was modified to have a primary care focus. Some of the course content and subsequent assessments may not be directly applicable to the PCPA (as detailed in their job description) in the primary health care setting. The broad knowledge, however, gave the student a comprehensive base for understanding the tasks and issues in the wider community.

The course assessment consisted of a skills checklist, 13 worksheets, completed CPR level 2 and a first aid course, a practical competency assessment, a case study and a presentation.

The generic skills checklist contained many tasks which were not applicable to a PCPA’s role and work environment and a separate checklist was developed. The checklists contained a mixture of clinical, non-clinical and administrative tasks/skills. This checklist was detailed and covered most of the key tasks in the PCPA job description.

**NURS S504 (PCPA Course)**

In the first semester part A had an emphasis on bioscience and common related conditions in general practice. The course focused on the students’ knowledge of anatomy and physiology and developed their skills base.

**Part A: Assessment**

- MCQ bioscience weekly tests which required 50% to pass 9/12 of the tests.
- A skill/task list which required to be submitted (See Appendix 14, page 69).
- A formative portfolio.

The second semester of this course continued to develop critical thinking and built on the base blocks of Part A and the HCW course. There was one session on career development with goal setting to identify ongoing learning needs.

**Part B: A portfolio of evidence was required**

A clinical self-assessment, one practice focused goal and evaluation, one exemplar and practice-based evaluation, one assignment and completion of Part B checklist. The assessments of Part A and Part B were combined to produce a portfolio at the completion of the course.
555401 Health and Environment (AUT)
This course introduced the link between the environment (physical, psychological and cultural) on an individual’s or group’s health issues. The focus was on global systems and their effect on New Zealand society, and encouraged students to reflect on their individual and group influence on the environment.

Assessment for this course involved online tests, an individual assignment and a group project. There were 10 online tests worth two percent each; each test was designed to gain knowledge and understanding of information provided in lectures and readings.

The individual assignment required students to critically assess a current environmental issue in New Zealand, how it was being managed, who was managing the issue, the relevant legislation, and how it impacted on the health of the community.

The team project required the students in groups to consider a health issue affecting New Zealand and to develop solutions to this issue. The students were required to provide evidence that justified their solution. Working as a group was designed to teach the students to work as a team, to negotiate possible points of contention and to learn how to give and take constructive feedback. At the end of the project the students were required to reflect on what went well and what didn’t, to encourage them to think critically of their own communication and negotiation skills.

555101 Lifespan Development and Communication (AUT)
This course provided an overview of human development and the challenges that were faced during the lifespan. It identified how individuals grow in a number of different domains, the theorists commenting on lifespan and the different ways in which communication can be altered to be most effective for different periods in the lifespan. This was a vital component of the PCPAs education as part of their job description involves health promotion within the practice.

The course detailed ‘normal development’ so that students understood what to expect of their patients in different stages of life and begin to identify and address difficulties before they became problematic. It focused the students on the identification of age appropriate care for individuals.

The Code of Health and Disability Services Consumers’ Rights and ethics were also components of this course. Students had previously been introduced to the code of practice in other courses and this course encouraged students to think more in depth about these issues.

Assessment involves the following:

• Attend five out of six communication tutorials.
• A written lifespan narrative.
• MCQ tests.
• A peer-wise assignment.
Aims and objectives

The aim was to provide a demonstration programme to demonstrate the value of the role of a Primary Care Practice Assistant (PCPA) in Waitemata PHO across a variety of general practice settings and to support this by a programme of academic and work based learning which was to be provided through Level 4 work based courses at Unitec Institute of Technology and by Level 5 papers at AUT University.

The key objectives of this demonstration were to create a new role which supports primary care practices and to demonstrate the value of the role of a PCPA in Comprehensive Health Ltd in association with Waitemata PHO across a variety of general practice settings.

Specific tasks of the demonstration team were:

- To develop and establish the role and responsibility of practice for a practice assistant in primary care in a range of general practice settings that can be standardised across New Zealand.
- To implement and evaluate a programme of study to support primary practice assistants in fulfilling their role and to provide some standardisation for the position across settings.
- To determine and evaluate the cost and benefits of implementing the role and assess the possible impact on the health force.
- To assist PHOs and DHBs in New Zealand who may be interested in introducing the course and training in their localities.

An evaluation of the programme was required by Health Workforce NZ.

Prior formative evaluations

Two reports on the evaluation were completed in June and December 2012. The first was a progress report focused on the recruitment, development of education and training programmes, description of sites and the educational and prior employment experiences of the PCPAs. The second report at the end of 2012 focused on the experiences of nursing and administrative staff in the second half of 2012. Both formative reports relied on documentary evidence and face-to-face interviews. See Appendix 2 for summaries of these reports.

The current evaluation

A summative evaluation of the implementation, training and benefits of the Primary Care Practice Assistant demonstration programme developed with Health Workforce New Zealand was conducted by AC Research between 1 March 2012 and 30 June 30 2013.

The goal of the innovation project was to develop the role of practice assistant, including clinical and administrative duties, as well as developing a training package to support the new role. The demonstration aimed to test the utility of the role, scope the extent of practice and gather evidence around time released for enhanced activities for other health professionals, including general practitioners and practice nurses (Description of the Innovation Services: Schedule 3, 2.1).

The purposes of this summative evaluation were to measure the outcomes and indicators set out in Schedule 6.2 of the Health Workforce document (see Appendix 3, page 59).
Methodology

Design of evaluation

The evaluation contained both qualitative and quantitative components in the evaluation of the success of the demonstration programme. A qualitative research design was the most appropriate approach to contend with the experiences of a range of primary health workers and the patients they served. Quantitative analysis of measurable data gave information on the cost benefits of employing a PCPA and where rankings provided numerical information. This augmented the qualitative information to determine the weight given to individual opinions. Document analysis was appropriate to evaluate the programmes of education and training and quantitative components were utilised in order to evaluate any financial and workload implications of the role. The combination of these methods gave a disciplined approach to the evaluation.

In order to determine whether or not the specified goals and objectives have been achieved, a range of data collecting methodologies have been utilised. These included:

- Surveys.
- Interviews (both face-to-face and by telephone).
- Document analysis of training packages, tertiary course curriculum documents.
- International and national literature.
- Analysis of financial and other consequences of employing a PCPA in a practice.

The triangulation of information from multiple sources provided confidence in the conclusions. The current evaluation phase focused directly on the specific goals and outcomes set out in the evaluation schedule and included evidence from doctors, practice managers, practice nurse managers, PCPAs and patients. In addition the analysis of current international literature was included to update discussion, development and expansion of any similar roles to the PCPA.

The key components of this final phase of the evaluation were to:

- Provide information regarding any barriers and impediments to making the required changes to the regulations and subsequent implementation.
- Evaluate the patient experience.
- Quantify the efficiencies generated by the model being trialled and evaluate the safety of the innovation.
- Make recommendations about any legislative or regulatory changes required to enable the model to be implemented and extended.

Informant selection

In the first year of the evaluation, data was based on face-to-face interviews with 10 PCPAs from 10 selected practices. Where there was more than one PCPA in a practice the choice of the interviewee was made in discussion with the project manager/clinical co-ordinator and the practice manager; practice nurse managers and practice managers were also interviewed. Practices were selected to gain information from the range of practice variables identified as important. These were; rural or urban, geographic location, size of practice, and patient ethnicity.

Following discussions with the practice staff and project manager/clinical co-ordinator, a purposive selection for the current phase of the evaluation was used to ensure that the general practitioners and nurses were those who had experienced the most contact with PCPAs through either having an assigned PCPA or being the contact person for task delegation in the practice. Steps were taken to ensure that the most information rich informants in each practice were interviewed.
This resulted in interviews with:

- 19 PCPAs.
- 10 General Practitioners.
- 10 Practice nurses.
- 10 Practice managers.

A patient satisfaction survey was conducted in 18 practices over a three week period.

**Primary Care Practice Assistants (PCPA)**

All 19 PCPAs were interviewed.

**General practitioners (GP)**

A sample of 10 GPs with a working relationship with a PCPA or who represented practices in which PCPAs were working in a model which released nursing staff to work most effectively in nursing practice was identified and all agreed to be interviewed. A series of telephone interviews were conducted near the end of the final semester. This time was chosen to allow the longest time of association of the PCPA with the practice.

**Practice nurse (PN)**

One practice nurse manager or the PCPA mentor in 10 practices was interviewed. Eight of the interviews were face-to-face and two were conducted by telephone. The decision to interview was made on the advice from the PN regarding who had the most information on any effect of the work scope of the PCPA in the practice on the work of the practice nurses and doctors in the practice. In some practices staff changes had resulted in a short period of working with a PCPA. In two practices two positions (PN and PM) were held by the same person.

**Practice managers (PM)**

Practice managers in 10 practices were interviewed. These were staff who had the responsibility for the provision of quantitative information regarding the financial implications of having a PCPA employed. Access to this information was difficult to obtain as there was no direct link to analyse an effect on workload and as a result, answers were usually an estimate. The interviews with practice managers were conducted by telephone at a time suitable to the interviewee. Following the first interview which was conducted as a demonstration interview, any necessary changes were incorporated.

**Patients**

A convenience sample was identified by inviting patients consecutively until 15 questionnaires were taken in each practice. This sample sought to capture as much patient variation as possible with an over-sampling of Māori. Attention was given to ensuring that there was a mix of patients who had had more than one exposure to the health services of the PCPA and those who had seen her only on the current visit. Those patients who were infirm, distressed or too ill were not invited to participate. Patients who were not proficient in English were invited to participate if they were accompanied by an English-speaking companion.

**Data collection procedures**

**Patient satisfaction surveys**

Information from patients was restricted to those practices with a publicly visible PCPA. In May 2013 PCPAs in 12 practices were given 15 Patient Satisfaction Surveys each to invite patients to participate anonymously. Where there was more than one PCPA the surveys were divided between them. The invitation was given to patients at the completion of an interaction to provide a purposive sample of patients within a limited time frame. The completed surveys were sealed in a stamped addressed.
envelope and either deposited in a specific postal box held at reception or posted individually by a patient.

One set of questionnaires was translated into the Tongan language and the four returns in Tongan were translated by an independent DHB translator.

**Informant interviews**

Telephone interviews with general practitioners and practice managers were conducted near the end of Semester 3 at a time convenient to the GP or PM. Interviewees were offered the opportunity to sight the questions before the interviews. The interviews were recorded and transcribed and themes drawn from the answers.

Face-to-face interviews were conducted with the PCPAs and practice nurses in the Auckland area and by telephone in Northland. PCPAs and practice nurses were emailed the questions prior to the interviews. The interviews were recorded and transcribed and themes drawn from the answers.

**Programme data sources**

Evidence from programme documentation was available from Unitec, AUT and from the project management team. This included:

- Planning documents for the development of the programme, including reports of initial focus groups with GPs (in the development phase of the programme)
- Curriculum documents for the four papers included in the course of study.
- Job description information including professional development, relationships, communication, accountabilities and nursing and medical skills.
- Workplace notes produced by the project manager/clinical co-ordinator.
- Skills log listing completions; both required by the programme and idiosyncratic to particular practice opportunities.
- PCPA employment and educational history and personal characteristics.
- Individual practice structure pertinent to the programme development.
Results

Patient satisfaction survey

There were 174 responses to the patient satisfaction survey from 12 clinics (97% response rate); see Appendix 4 for survey questions. Ninety-two patients wrote reasons for their ratings. Sixty percent of the patients were commenting on their first exposure to the PCPA.

Satisfaction levels were very high with 80 percent of the patients reporting they were highly satisfied with their interactions with the PCPA and a further 14 percent being very satisfied. Only two patients were not satisfied; one who was highly dissatisfied with seeing the PCPA reported that: *I felt it was a waste of my time.* Another patient who was neutral about the role wrote: *I prefer to see the doctor sometimes. I have more confidence in him.*

One hundred and sixty eight (97%) of patients reported that they “would be happy to see the PCPA again”. The most common explanations for patient satisfaction were that the PCPAs provided an efficient process, lessened the waiting time, and made it easier for the doctors and nurses, and they referred them on to nurses if the tasks were outside their competency levels. The fourth most common comment was that the PCPAs were informative and friendly.

The patients were also asked to enumerate the range of tasks which the PCPA had performed during their contact with them. The most commonly reported tasks were: taking blood pressure; administration; taking weight; assisting the doctor and helping with dressings. The responses indicated a good understanding of the of the PCPA role as identified tasks correlated well with the breadth of the role.

General comments

One hundred and twelve general comments were included in the survey open question, and all were positive about the PCPA role in general practice. Many of the comments reinforced those made above such as; the role was important to free up doctors’ and nurses’ time, it lessened waiting time and made the patients feel valued and cared for. Others commented that the PCPAs knew their limitations and would hand over to a doctor or practice nurse when required. New information related to the personal characteristics of a PCPA such as being understanding, caring, friendly, confident, efficient and helpful. For example one patient wrote: *She lifts your spirits when you are down.*

Specifically, patients commented that the role of the PCPA was an important one and that there was scope for it expanding in the future. Comments which illustrate these suggestions are:

- *It is an important role to help patients.*
- *There is more one on one interaction.*
- *I would like to see the PCPA again.*
- *They are good at giving information at a level I can understand.*
- *They make us feel good and cared for.*
- *The role should be nationwide.*
- *Once doctors have tried PCPAs they will not want to be without one.*
- *It is a very varied role. I would like to do something like this myself.*

Another patient commented that it was good to have someone answering the phone rather than having to leave a message. S/he wrote: *The PCPA answers the nurse line and we don’t get an answer phone; we get the answers straight away.*
Table 1: Quantification of general comments

<table>
<thead>
<tr>
<th>Comment</th>
<th>Number commenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great asset to the practice</td>
<td>46</td>
</tr>
<tr>
<td>Positive personal characteristics of PCPA</td>
<td>33</td>
</tr>
<tr>
<td>Frees up doctors</td>
<td>15</td>
</tr>
<tr>
<td>Lessens waiting time</td>
<td>12</td>
</tr>
<tr>
<td>Future expansion of role</td>
<td>6</td>
</tr>
</tbody>
</table>

Summary

The results of the patient survey showed that there was a very high level of satisfaction with the role of the PCPAs as reported from 12 of the 13 practices⁴. While the comments need to be read with the understanding that 60 percent of respondents had had only one interaction with a PCPA and were confined to an individual narrow range of interactions, overall the supporting answers showed a high level of confidence in the wider role. Those patients who completed the questionnaire, have responded positively to the opportunity for a level of care not previously widely available in busy practices and have also recognised the value of the assistance given to the medical and nursing staff.

PCPA interviews

The majority of PCPAs were either highly satisfied (63%) or very satisfied (16%) with their role. See Appendix 5 for list of questions. The two who were dissatisfied had enjoyed the course but were restricted by their practices in the time they were allocated to clinical aspects of their training.

The roles of the PCPAs varied considerably between practices, from solely clinical work, to a mix of clinical and administration work, to answering queries on the nurse line or to mainly reception and administration. The levels of direct patient contact also varied among practices.

There were several positive aspects which were consistently reported such as: the patient contact, the variety that the role offered, and the training they had been part of. For example:

- *I love the hands on with the patients – you can make a difference, especially to the elderly (#5).*
- *The patient work is something I can own (#12).*
- *I like a balance between patient contact and having time out doing things like recalls (#10).*

However, two of the PCPAs who had not done clinical work previously found some aspects challenging in working with patients who were emotional or did not want to see them.

- *It was hard not to take it personally when the patient said they didn’t want to see me, they only trusted the doctor (#16).*
- *I find the unknown of patients (and their behaviour) to be worrying (#15).*

Equal numbers of PCPAs reported that they were working up to the level of their competency as those who were aware that they needed more practice. Several PCPAs thought that their competency and confidence would increase over time and they could be doing more tasks and making their role more satisfying. These included opportunities to be involved with immunisations, influenza vaccinations, nurse line queries and auditing procedures and processes, and making change suggestions.

The two PCPAs who were dissatisfied with their role reported that they had only one day a week in which they were allocated clinical tasks which did not allow them to develop competency in the skills learned.

Four PCPAs reported that the job was better than expected; 10 said it was what they expected as their clinics gave them a good description of the role prior to starting the training. Several PCPAs reported that there was more administration in the role than they originally thought. The range of comments is illustrated below.

- *I hadn’t done any clinical work before this so I was apprehensive – I love it! (#9).*
- *It is a lot more work than I used to do and no one covers me for the work I used to do (#15).*

⁴ One practice was excluded because the PCPA had limited patient contact (mostly to telephone contacts), and the breadth of the role would not be recognised.
I get paid the same for twice the amount of work (#1).
I feel that the job was not as expected as too much time is spent on administration and not enough on patient contact (#7).

PCPA perceptions of changes in staff attitudes to the new role

Registered nurses

Some PCPAs reported that one of the concerns expressed by registered nurses when practices first opened up this position was that PCPAs might “take over” some of the tasks previously completed by registered nurses and consequently threaten their position in primary care. Indeed, initial attitudes by practice nurses towards the PCPA role appeared to be mixed and to vary from nurse to nurse. The PCPAs said that some practice nurses did not know where the PCPA role fitted into the practice with some nurses being hesitant and expressing comments such as: if you (PCPA) are doing that… what am I going to do?

Other practice nurses had been unwilling to delegate, due in part to a lack of understanding of the role. As the nurses became more familiar with the opportunities and the competence of the PCPAs increased, attitudes became more positive. Their delegated tasks and responsibilities increased. The PCPAs commented that the project manager/clinical co-ordinator worked at increasing the understanding of staff regarding this issue to the extent that:

Their attitude has changed completely from when we started to now (#3).
They would like more of us – it makes their job easier (#19).
Communication is a key component to each of the roles understanding each other and working towards a more efficient service (#14).

Positive aspects of the role reported to have been discussed with the PCPAs by the practice nurses is that the PCPA role has:

• Freed up the nurses to start nurse-led chronic care clinics.
• Freed up the nurses to be less rushed and spend more time with patients.
• Released nurses from tasks that “are a waste of their time”.
• Reduced the time patients have to wait for attention.
• Taken over the nurse line from an enrolled nurse, freeing up the enrolled nurse to help the practice nurses.
• Freed up the nurses to spend more time phoning patients and answering their questions, and by taking care of the restocking and autoclaving.
• Allowed nurses to see more patients each clinic by doing the pre-assessment/observations.

However, some PCPAs who were not totally satisfied with their scope of practice said that at times they had felt that some of the nurses did not value the PCPA as well as they should. This related to PCPAs not having the ability to block off time to complete set tasks and to have to accept less attractive jobs from a range of other members of the practice.

The nurses treat me as if I am a step down from them and fob off the unpleasant jobs on me (#12).
Their attitude has completely changed from when we started to now (#3).

We are not getting time to do our set tasks – we can’t block out time – the nurses don’t realise how busy we are (#12).

The current position reported by all the PCPAs was that the registered nurses in their practices liked the PCPA addition to the practice. One of the clinics had handed over the entire recall system to the PCPA. Individual PCPAs who reported specific innovations in their practices which had resulted from their new role included:

• Helping with Cornerstone accreditation.
• Doing pre-assess/triage for more doctors.
• Combing new patient notes identifying illness/recalls and things that need doing before a consultation.
• Revamped the recall system.
• Before school check administration.
• Helping doctors with skin clinic.
• Freeing up nurses have allowed them to do a diabetes clinic for a full day.
Roles which would have had to be done by a registered nurse

The roles which would normally have been done by a registered nurse and which were now being done by the PCPA are listed below.

<table>
<thead>
<tr>
<th>Task</th>
<th>Number of PCPAs doing these tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recalls</td>
<td>12</td>
</tr>
<tr>
<td>Dressings (basic)</td>
<td>10</td>
</tr>
<tr>
<td>Giving results</td>
<td>7</td>
</tr>
<tr>
<td>Restocking</td>
<td>7</td>
</tr>
<tr>
<td>Pre-assessment</td>
<td>7</td>
</tr>
<tr>
<td>Assisting with minor surgery</td>
<td>6</td>
</tr>
<tr>
<td>Recordings/observations</td>
<td>6</td>
</tr>
<tr>
<td>Autoclaving</td>
<td>5</td>
</tr>
<tr>
<td>Pregnancy tests/urine tests</td>
<td>5</td>
</tr>
<tr>
<td>Dashboard</td>
<td>5</td>
</tr>
<tr>
<td>Venepuncture</td>
<td>3</td>
</tr>
<tr>
<td>Visual acuity</td>
<td>3</td>
</tr>
<tr>
<td>New patient reviews</td>
<td>3</td>
</tr>
<tr>
<td>ECG</td>
<td>3</td>
</tr>
<tr>
<td>Chaperoning</td>
<td>2</td>
</tr>
<tr>
<td>Answering the nurse phone</td>
<td>2</td>
</tr>
<tr>
<td>Chasing results</td>
<td>2</td>
</tr>
<tr>
<td>Interpreting</td>
<td>1</td>
</tr>
<tr>
<td>Health and safety</td>
<td>1</td>
</tr>
</tbody>
</table>

Receptionists

The PCPAs also reported that the receptionists were currently positive about the role. As the majority of PCPAs had been in reception or administration in the practice before the demonstration programme, they currently had allocated time slots as part of their job description or could slot easily slot into that role should there be a need. One PCPA commented that the receptionists had a:

*Positive response to the role as we can do things with a patient while they are waiting and then the patients are not sitting staring at the receptionists (#1).*

Reception tasks being done by the PCPA

Where the PCPA covered the receptionist, the following is a list of the tasks they undertook.

<table>
<thead>
<tr>
<th>Reception tasks</th>
<th>Number of PCPAs doing these tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covering receptionists for breaks</td>
<td>7</td>
</tr>
<tr>
<td>Administration (incl. rosters, time sheets)</td>
<td>5</td>
</tr>
<tr>
<td>Faxing clinical notes/referrals</td>
<td>3</td>
</tr>
<tr>
<td>Posting out recalls</td>
<td>3</td>
</tr>
<tr>
<td>Covering a day a week</td>
<td>3</td>
</tr>
<tr>
<td>Updating patients enrolments every two years</td>
<td>2</td>
</tr>
<tr>
<td>Updating patient files</td>
<td>2</td>
</tr>
<tr>
<td>Doing up PowerPoint presentations</td>
<td>1</td>
</tr>
</tbody>
</table>
PCPA satisfaction with tertiary courses

The ratings for both courses (May/June 2013) showed that PCPAs were generally moderately satisfied with both the AUT and Unitec courses. These ratings need to be interpreted within the context of most students’ prior low secondary school levels of academic attainment and few with post-college tertiary level education. Given these constraints and the difficulties in weekly travel to Auckland, travel between two institutions, and fitting study into an already busy lifestyle for those who have dependent families, it is commendable that there has been a very high pass rate for the first two semesters, with all except one PCPA passing all courses. One had to re-sit a section to meet competency and has passed.

There were different strengths reported at each institution with one providing a wide range of topics, having good student contact processes and excellent guest speakers. The other institution was reported to have well-organised lectures, internet based homework and excellent small group tutorials.

In contrast there were a number of areas for which improvements were suggested. For the first institution, the PCPAs would have appreciated the tests to have been available online with remote location access, more access to develop academic skills such as learning Endnote, how to construct academic essays and time to practice new skills. In the second institution, the students would have preferred to have some specific focus on topics pertinent to primary health care and opportunities for some personal contact with academic staff rather than relying on electronic contact.

Due to the time constraints in starting this demonstration programme, existing courses in both of the institutions were included. This has proved to be only partially satisfactory. Only one of the courses was specifically designed for teaching primary care skills and issues. Each course attracted specific student comments which tended to reflect the student’s prior knowledge or personal interest and none revealed common themes. A range of these are below.

- Able to cross credit this one to a nursing course (#9).
- Highlighted the effect on the young and elderly (#11).
- The assignment shouldn’t have been on a fictitious problem – would have been more pertinent if it was a real and current problem (#17).
- Why did we need to learn about algae and plants? (#19).
- Group project good – made us work as a team and listen to others’ opinions (#5).

Students reported negative comments. There was universal complaint that there was not enough time included for practice in the courses which introduced clinical skills. In addition the access to the SIM lab was reported to be limited due to equipment being broken or not available; some requirements such as weekly goal setting, journals and exemplars were not considered useful by some students.

Suggestions for future academic courses

The need for multiple opportunities to practice skills with supervised and checked opportunities was the most frequent suggestion, with the SIM lab being a very useful addition to the training. However, students considered that theory and demonstrations in the lab were less useful use of the allocated time. Secondly, to have notes available before class was extremely useful to first-time tertiary students.

A purpose-built academic programme with the development of courses focused on the PCPA role was seen as necessary to eliminate repetition of theory. There were suggestions that guest lecturers would have better information to understand the role and to pitch the presentation at the ‘correct level’. Some students suggested the course be presented in blocks with, for example, a block on administration and one on body systems. Interestingly, this is similar to the model utilised in some states in America (see literature review, page 50).

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5 This PCPA has to resit one section as she has not yet met competency on one assessment item.
6 It is universally a consistent perception by students that requirements not part of assessment are not highly rated.
7 These were not available for all courses.
In-practice training

The PCPAs were highly satisfied, with 18 (95%) rating the in-practice training as excellent or good. PCPAs rated their training in practices very highly as they reported that the nurses are: Very supportive (n=5); Easy to approach (n=4); is delivered appropriately (n=1). However, access to assistance to discuss issues or to augment information depended on how busy the nurses were. One PCPA who had had a scheduled monthly meeting for the first year has not had any in the second year, and would like it reinstated at least once a month as the formal time slots were very valuable. Another said that she learnt more from clinic staff than from the courses. Another student said that the practice has slotted me into the postgrad nurses training – I get more info from that (#7).

Supervision in the practices was variable and in some cases dependent on the PCPA being proactive. Seven of the PCPAs reported that both doctors and nurses gave information and assistance only if she asked for it; otherwise she was left to do things by herself. A similar number of nurses watched them do some procedures or checked them when completed. Others (n=4) reported that both doctors and nurses direct me and I follow orders or that the PCPA worked directly with a doctor or reports back to a nurse after patient contact.

In addition to the practice staff, providing supervision was the very important role of the project manager, a senior registered nurse with teaching responsibilities at tertiary level who had a schedule of regular practice visiting. In the role of project manager/clinical co-ordinator, she was available on study days and through this had weekly contact with all PCPAs. In addition, Auckland practices were visited every two weeks for the first year and then three-weekly in the third semester. Northland practices were visited monthly throughout the demonstration programme. The PCPAs commented that she was very supportive and passionate about the programme and was helpful in giving feedback and answering any questions each PCPA had on those visits.

Some academic course tutors were helpful in responding to questions when contacted by students.

Difficulties with the training programme

The balance between work – life – study - travel was the difficulty most reported by over half (n=10) of the students. Those with dependent children particularly found the early starts difficult to manage with lack of parking adding to the difficulty of the study day.

It was very hard to manage this with working full-time and juggling a family (#19).

It was hard to get the balance, particularly since I haven’t studied for a long time and it took me longer (#14).

Secondly, there were concerns regarding the future employment options at the end of the programme. A small number (3) of PCPAs who had been quite satisfied with the previous work they were doing in a practice such as reception or administration were unsure of their future. Alongside this were questions regarding the lack of clarity about the status of the position.

I am concerned about what we do if we don’t like the job – when we started the manager said if we don’t like the job we don’t have to do it - don’t think that is the case now – I guess I’ll just end up doing shitty nurses’ jobs that I don’t want to do (#13).

I enjoy the front desk and don’t want to swap one for the other (#4).

Now that we have this extra talent maybe they’ll pay us more – but that will worry them and they might tell us to go back to the front desk (#9).

As there was no standardised requirement for payment while on a study day, there was a wide range of financial commitment by practices which resulted in some PCPAs being paid for a full day, others were part paid and others were not. This resulted in some dissatisfaction. For example: My study day is not considered a work day so I am having to work 6 days p/wk (#5).

Safety in the practice

The issue of ensuring safety in practice was discussed regularly as a specific issue and throughout the whole programme. PCPAs were clear that they were task trained and worked under delegation. This provided safety for patients and for themselves. There were checks and balances provided by the nursing
and medical staff and some PCPAs (n=7) said they were encouraged to always ask questions if they were unsure of anything. In addition, the PCPAs had confidence that they were able to ask for supervision or checks for any procedure or process.

PCPAs reported that they were aware of their boundaries; both clinical and personal. One of the first tasks they had learned was to clarify to a patient what their role was; to differentiate between registered nurses and their position. Some (n=4) PCPAs reported that they documented every conversation with a patient. They reported that they were able to work with medically normal laboratory results and knew when it was important to hand over to a doctor or nurse if they were unsure of any report or if a patient asked any questions. However, one PCPA commented that she sometimes had to remind practice nurses what she can and cannot do. She said: *I sometimes think the practice nurses think we can do more that we are authorised to do (#9).*

Future employment and educational options

Four of the 19 PCPAs had decided to continue study for a nursing degree and three were actively developing this option with the support of their practices.

The demonstration programme has opened opportunities for a number of PCPAs who now have an interest in further education. These are all augmenting interests which have arisen from the courses they have completed. More than half (63%) of the PCPAs independently identified areas of education as future options for training.

<table>
<thead>
<tr>
<th>Courses PCPAs would like to attend</th>
<th>Number of PCPAs commenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health promotion updates (smoking cessation, diabetes, etc)</td>
<td>6</td>
</tr>
<tr>
<td>CPR</td>
<td>5</td>
</tr>
<tr>
<td>Any courses the practice nurses attend</td>
<td>5</td>
</tr>
<tr>
<td>Nursing training</td>
<td>4</td>
</tr>
<tr>
<td>First aid</td>
<td>3</td>
</tr>
<tr>
<td>Infection control</td>
<td>1</td>
</tr>
<tr>
<td>Palliative care</td>
<td>1</td>
</tr>
<tr>
<td>Triage/assessment course</td>
<td>1</td>
</tr>
</tbody>
</table>

PCPA suggestions for the future configuration of the programme

There were three themes from the PCPA suggestions to improve the programme:

- Changing the programme structure.
- Adding additional content.
- On-going educational opportunities.

The major issue for a number of PCPAs was the weekly necessity for a whole day of lectures and tutorials which broke into a working week. Particularly for those students who came from Northland and for the northern aspects of Auckland, a whole-day course involving a lot of travel was too difficult for personal and employment reasons. Understaffing for this day was a problem for some practices, especially those in Northland, as a relief person was difficult to obtain. Adding to this concern was the difficulty of working on two campuses which made for a rushed day. *One day a week is too rushed – rush from Unitec and AUT and have to change mindset (#19).*

Two suggestions were having a one year course or to have block courses. In either case most students reported that they would prefer to have fewer breaks during a day to shorten the day. Secondly, a number of suggestions were made for augmenting the content of the courses and these related to practical skills and increasing their understanding of the boundaries of normality.

8 One of these PCPAs is now pregnant and will not be able to take this option in the near future.
Other suggestions the PCPAs had for the course were:

- More practical experience.
- Manual BP and why to do it.
- Understanding basic lab results.
- Basic ECG rhythms (when to panic).
- Time in a rest home to learn to talk to people (human factor).
- More anatomy and physiology.
- More on basic conditions (e.g. diabetes, asthma).
- Better wound care training.
- Teach practical as it will be done in reality.
- A class on how to deal with people would have been beneficial.

The PCPAs suggested some academic skills teaching would be useful such as an academic writing course/lecture: *I haven’t been at school for a long time, I had no idea how to start* (#5); how to use Endnote: *I had never heard of it and tried to do it all by hand at the beginning* (#16); and to develop a programme of postgraduate training to ensure the continuation of opportunities for learning.

Other comments

The PCPAs reported that the whole programme had been a good experience and they would like to see the position go ahead as it was a very marketable role. There were comments that most of the patients don’t know (or care) who we are: *they don’t have a clue even after we introduce ourselves – they think we are nurses or receptionists* (#8).

The training programme was reported as essential to the validity of the role in primary care with a clearly defined job description of each practice to ensure the safety of patients and to delineate between other practice roles. The PCPAs wanted this role to be defined by a training programme. The following comments illustrate these concerns:

- *No one should be able to do this role without the training – people are vulnerable* (#4).
- *Need to have a close look at the job description - is it going to be taken to EN level? We seem to have done much of the same training – they feel we are encroaching a bit particularly in minor OT* (#7).

PCPA time analyses

PCPA 1 day and 2-4 day time records

This section is divided into an analysis of time recordings and a financial analysis of any cost savings.

One-day recording

The PCPAs were asked to provide information on one day’s activities in a minuted log. This resulted in a 90 percent response rate.

Data was supplied in the following categories: the time in minutes that they expended on any activity for nurses, GPs, receptionists, practice managers and on behalf of Lab Tests taking bloods. The total number of minutes expended on behalf of each group is summarised below.

<table>
<thead>
<tr>
<th>PCPA total time in a day</th>
<th>On behalf of practice nurses</th>
<th>On behalf of GPs</th>
<th>On behalf of receptionists</th>
<th>On behalf of practice managers</th>
<th>On behalf of Lab Tests</th>
</tr>
</thead>
<tbody>
<tr>
<td>4,258 minutes 70.96 hours</td>
<td>1,012 minutes 16.87 hours</td>
<td>1,781 minutes 29.68 hours</td>
<td>300 minutes 5 hours</td>
<td>80 minutes 1.33 hours</td>
<td></td>
</tr>
</tbody>
</table>

A full breakdown of the total time worked is in Appendix 6, page 62.
Most of the PCPA work was spent on behalf of the nurses, followed by work on behalf of receptionists and then the GPs. This shows that, on the trial day, the PCPAs were working mostly on tasks which would have otherwise been covered within a nurse’s work day. There were five PCPAs who did not work with any doctor during that day. There were three PCPAs who worked with the practice manager, one of whom worked for nearly four hours.

The data was presented in this form to show the very wide range of time in minutes worked by individual PCPAs and the high involvement in nursing tasks. It is also important to note that PMs reported very little PCPA assistance for themselves which does not correlate with the information from this sample day.

Two to four-day recording

A further time trial was conducted over two to four days. On this occasion the data was collected by the PCPAs entering each activity on the practice computer. This program was developed by one practice manager from a demonstration practice. Fourteen PCPAs completed this study.

The data was presented in terms of the percentage of the total time the PCPA worked on those four days. The intention of this was to compensate for the wide range of hours worked by each individual PCPA as the range of employment was for four days in a designated week from a range of 20-32 hours of employment in this week.

9 Note that one day a week was out of the practice for the educational programme and study.
The data confirmed the high percentage of the PCPA time that involved nursing activities and the relatively small time spent assisting the GPs. This information showed that the intention of the programme to provide relief from non-nursing tasks for registered nurses has been successful. The doctors have been less active in delegating work to PCPAs to enable them to focus on more productive clinical work. Of note is PCPA #11 who worked nearly 80 percent of her time on those days with practice manager/administration.

**Main themes from time analysis**

There is a very wide variation in the use of the PCPAs by the practices. PCPAs #1, 3, 8, 12, and 19 did not work with the GPs at all. PCPA #12 worked exclusively with the nurses. Other practices utilised PCPAs across all staffing categories. There was also a wide range of the hours entered by the PCPAs (range 5.38 – 9.06 hours). Only one PCPA stated that she had had a short day. This may reflect the part-time hours some of the PCPAs work.

An interesting comparison can be made between the responses of the practice managers to the question “Has the PCPA been able to reduce your workload?” and the response of the PCPAs to the question “(Time spent) assisting the practice manager”. Only three practice managers reported that the PCPA reduced their workload; in contrast seven PCPAs claimed they spent a total of five hours on that particular day assisting the practice manager.

Three GPs stated in their interviews that the PCPA worked with them full or almost full-time. This is not reflected in the returns from the PCPAs for either of the selected methods. Where the PCPA worked with doctors, in some practices, this took the form of triaging a patient before the doctor came in, or of assisting the doctor with minor procedures.

Both sets of data confirm the high percentage of time working with the nurses and with the practice manager/admin. 

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10 PCPAs may have used the word *triage* to describe the range of tasks they completed prior to the consultation such as taking blood pressure, height, weight and ascertaining the reason for the visit.
Cost analysis of any savings achieved by the use of the PCPA

The PCPAs all worked different numbers of hours, so the figures in each of the three case studies relate to one individual PCPA. The studies were conducted using the data obtained from the one-day study.

The practice nurse wage rates quoted are those which are normally the maximum rate paid to a senior primary care practice nurse. The salary/earning rates for GPs are extremely variable, so the rate for a GP has been taken as that which is normally paid to a locum. The PCPA rate has been taken as the representative pay rate for a PCPA in the sample.

The three case studies selected were those who: were most utilised by the nurse; most utilised by the receptionist and most utilised by the GP.

Case 1. The PCPA most utilised by the nurses (#19) (7.5 hours)

<table>
<thead>
<tr>
<th>Hours of work</th>
<th>Hourly rate</th>
<th>Wages total</th>
<th>$ Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 hours by PCPA for nurse</td>
<td>$20</td>
<td>$140</td>
<td></td>
</tr>
<tr>
<td>7 hours by nurse</td>
<td>$37.50</td>
<td>$262.50</td>
<td>$122.50</td>
</tr>
<tr>
<td>30 minutes by PCPA for receptionist</td>
<td>$20</td>
<td>$10</td>
<td></td>
</tr>
<tr>
<td>30 minutes by receptionist</td>
<td>$25.60</td>
<td>$12.80</td>
<td>$2.80</td>
</tr>
<tr>
<td>Total savings (7.5hrs)</td>
<td></td>
<td></td>
<td>$124.80</td>
</tr>
</tbody>
</table>

Case 2. The PCPA most utilised by the receptionists (#7) (9.6 hours)

<table>
<thead>
<tr>
<th>Hours of work</th>
<th>Hourly rate</th>
<th>Wages total</th>
<th>$ Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 hours 30 minutes by PCPA for receptionist</td>
<td>20</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>5 hours 30 by receptionist</td>
<td>25.60</td>
<td>140.80</td>
<td>30.80</td>
</tr>
<tr>
<td>3 hours by PCPA for nurse</td>
<td>20</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>3 hours by nurse</td>
<td>37.50</td>
<td>112.50</td>
<td>52.50</td>
</tr>
<tr>
<td>10 minutes by PCPA for practice manager</td>
<td>10</td>
<td>3.33</td>
<td></td>
</tr>
<tr>
<td>10 minutes by practice manager</td>
<td>55</td>
<td>9.17</td>
<td>5.80</td>
</tr>
<tr>
<td>20 minutes work with the GP</td>
<td>120</td>
<td>40</td>
<td>46.66</td>
</tr>
<tr>
<td>20 minutes by the GP12</td>
<td>120</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Total savings for day (9.6 hours)</td>
<td></td>
<td></td>
<td>129.96</td>
</tr>
</tbody>
</table>

Case 3. The PCPA most utilised by the GP (#14) (6.5 hours)

<table>
<thead>
<tr>
<th>Hours of work</th>
<th>Hourly rate</th>
<th>Wages total</th>
<th>$ Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 hours 30 mins by PCPA for GP</td>
<td>$20</td>
<td>$90</td>
<td></td>
</tr>
<tr>
<td>4 hours 30 by GP (at locum rate)</td>
<td>$120</td>
<td>$540</td>
<td>$450</td>
</tr>
<tr>
<td>1 hour by PCPA for nurse</td>
<td>$20</td>
<td>$20</td>
<td></td>
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<tr>
<td>1 hour by nurse</td>
<td>$37.50</td>
<td>$37.50</td>
<td>$17.50</td>
</tr>
<tr>
<td>1 hour by PCPA for receptionist</td>
<td>$20</td>
<td>$20</td>
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<tr>
<td>1 hour by receptionist</td>
<td>$25.60</td>
<td>$25.60</td>
<td>$5.60</td>
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<tr>
<td>Total savings for day (6.5 hours)</td>
<td></td>
<td></td>
<td>$473.10</td>
</tr>
</tbody>
</table>

It should be noted that the greatest savings were achieved by the PCPA who relieved the GP despite the small number of hours that she worked.

11 Calculations are made assuming that the hours reported are a substitute for another staff member gainfully employed.
12 The earning rate for the GP has been taken as the normal rate by for a locum ($120/hour). The actual rates for a self employed GP would most likely be higher.
A further analysis was conducted showing the savings made with the *mixed* group of staff but reduced to an hourly rate. This is intended to compensate for the different range of hours worked.

In the circumstance where a PCPA spent her whole time relieving one specific person, the potential savings would be more marked. This did not occur in either of the surveys conducted but is shown here to underline the various savings that *could be made* if that option were utilised.

**Main themes from cost analysis**

- It is evident that the greatest financial benefit in using a PCPA is when they are attached to a GP and allow him/her to achieve either an increase in turnover or to provide other services to the patients which are chargeable.
- The next financial benefit is for the PCPA to be attached to a nurse which will allow the nurse to provide extra services which will attract charges or extra funding from the PHO.
- The least financial benefit is for the PCPA to relieve a receptionist. When rates of pay are considered, although the receptionist earns more than the PCPA, the difference is not great. This may be mitigated when this is at short notice and the difficulty of obtaining a replacement at short notice is high.
• If the PCPA was in a practice when she “triaged” the patient and allowed the GP to see an extra patient per hour, (20% increase), this would be a substantial financial gain to the GP.
• Although the savings achieved for PCPA #19 (case 1) and PCPA #7 (Case 2) were similar, it should be noted that #7 worked much longer hours to achieve a similar saving.
• It should also be noted that the substantial saving achieved by #14 in assisting the GP was achieved in the shortest time (case 3).
• While theoretically the greatest financial advantage to a practice is to employ a PCPA to work 100 percent with the GP, this is not always practical, and the use in a mixed role is more likely to happen. The financial advantage of 100 percent GP may be outweighed by reasons of convenience.

There is no guarantee that these work patterns will continue post-programme. Some PCPAs may be required to, or prefer to do more clinical work and others less.

The benefits of quality of care, better patient service and a more comprehensive service are discussed in following sections of the report.

General practitioner interviews

The responses of the doctors identified three main work style patterns, depending on the degree of workplace association of the doctor with a PCPA. This varied from a primary attachment of the PCPA to the doctor; a complete attachment of the PCPA to the nursing team and a mixture of attachments to the above and to the reception desk.

See Appendix 7, page 62, for interview questions.

Time factors

The doctors identified the time they worked in association with the PCPA and the effects or otherwise on their workload. There was a strong association between the attachment of the PCPA full-time to the GP and a reduction in workload or time freed up during the week. The doctors used this altered workload in various ways. Three of the doctors who worked in close association with the PCPA used her to welcome the patient, take him/her into the consulting room and perform a “triage” relating to the upcoming consultation. She would find the reason(s) for the patient’s attendance, refine these and conduct basic and relevant measurements such as weight, height, glucose, urinalysis, etc. The doctors found that this enabled them to move straight into a consultation and either spend more time with a patient or see more patients in an hour:

Well, she saves me about five minutes every consultation. The other thing that she does for me is that she does most of my non-clinical phone calls to patients such as reminding them to get a lab test and will phone patients to tell them what the contents of a lab test are. She does all my insurance medicals and ACC medicals preparation (#02).
She does all the patient screenings for me before I see the patient. The BP is done, the height, the weight and basic triaging. She finds out what the patient has come in for and I can read that before I go in and see the patient so I am ready to roll when I sit down and then I know what I am dealing with in that consult (#04).

Another doctor (#07) changed from a lesser association with the PCPA to a full-time association late in the demonstration:

And I certainly have a much more enjoyable consulting day. (Are you likely to continue in that mode?) Yes we are. The nurses have lost them now (#07).

All other GPs who were surveyed either worked occasionally with the PCPA or did not work at all with them.

The doctors were asked to estimate the number of hours in a week freed for them by the PCPA. There was considerable variability between those GPs who had a PCPA attachment and those who did not. The first group estimated that she released them for between 6-10 hours per week; all others estimated only a small number of hours.

It enables me to provide a better service and it lightens my general workload and I don’t have to do the paperwork after hours and my quality of life has gone up (#01).
Work style

The relationship between the time the PCPA was attached to the GP and the range of tasks the doctor undertook, the time in consultation, and any extra time that was allowed for special category patients of special interests was explored.

Dr #02 reported that there was time to see more patients and s/he achieved a bigger turnover with a small increase in the range of tasks. Dr #04 also reported a greater turnover but did more surgery and was able to spend more time with special categories and deal with walk-in patients. Dr #07 saw some more patients and found his/her time more productive. It allowed this doctor to spend more time with his/her special interests of palliative and dementia care. Dr #10 used the time to spend more time with patients. The remaining doctors noted little or no alteration to their work styles:

Yes, the main thing that I have noticed that the patients have got themselves more organised. They beat around the bush and have not got their thoughts together. They don't have to think about what they're going to ask because the practice assistant has already asked those questions and they have been able to figure it out and they will come in with a more specific complaint (#07).

Extra time for special interests

Half of the doctors described more time in which they could pursue special interests:

My particular interest is in skin cancer so I have managed to have a skin cancer clinic and in an afternoon I may well do four hours of surgery. I have a surgical list and we have a theatre here and I can do that (#02).

Doctors’ estimation of job satisfaction and quality of health care

The differences between the doctors who worked all the time with the PCPA and those who did not, were not as evident, with 80 percent reporting that there had been both an increase in their own job satisfaction and an increase in the quality of health care the practice provided:

She certainly has made a big difference to my nurses and they are freed up to do other things. The nurses are working at a higher level on their licences and they have done much more of the routine such as routine blood pressures, insurance medicals ECGs (#09).

It has gone up hugely. Normally when they come in you are so busy doing the basic things that you can now cope with extra issues (#04).

Hugely. Our quality has improved markedly. It is difficult with our population but now we have got our systems in place with our healthcare assistants we are way ahead and things are coming up quite nicely. The biggest thing for us there is a study with someone looking at standing orders with blood pressures and our HCAs will do this and the results of the study were that they are a lot better than doctors. I think we get our HCA is to do a lot more than other clinics do. A few of our HCA is almost enrolled nurses. We are using them to the maximum (#01).

The exception to the general increase in satisfaction was Dr #03 where the PCPA was involved with mainly administration and reception and only rarely with the doctor.

Financial considerations for doctors

None of the doctors was able to give accurate evidence for financial benefits.

Two doctors (#2 and #4) with whom the PCPA was working almost exclusively reported that this enabled them to see more patients in a day. Both were unable to quantify this financially. However, they reported that they would be able to see approximately one more patient per hour, which if they saw four patients per hour prior to the PCPA, would mean a 20 percent increase in patient numbers seen.

Other factors which might have had a financial benefit to the doctors were the achievement of health targets and nursing targets. Where the health targets were concerned, the response from 60 percent of the doctors was that they had improved. The Smoking Cessation target was mentioned by two doctors. However, the financial benefits from this were described as “trivial and usually well delayed” or they did not know. One practitioner indicated that their flu vaccine program had improved. Forty percent of the doctors considered that nursing targets had improved, but 60 percent did not know.

13 The PCPA in this instance was attached entirely to the nurses
Primary Care Practice Assistant Evaluation

A financial consideration for some GPs was that lack of cover for the day when the PCPA was away from the practice on study day. Doctors recognised that this was a financial consideration which would be remedied when the training course finished.

PCPA employment in training

The doctors were asked if they would employ another PCPA in training. Ninety percent would employ future PCPAs in training with two probably employing two PCPAs. Only one GP said he would “possibly” employ another PCPA in training.

One GP decided that the PCPAs were such an advantage to his/her practice that he/she stated that if one left, they might even add a couple more and if necessary would look for one trained in another practice.

*If one of them left we would replace them. We may even add a couple more. We would be happy to take them on while they were training. They are a net benefit in the long run. We are already looking for two more next semester at which time we are either going to poach or employ them (#01).*

PCPA course fees

When asked if they would be prepared to pay course fees, the response was less enthusiastic, with six agreeing (four of these were qualified with probable/possible), two said no and two did not know.

PCPA employment for the future

All doctors would employ PCPAs in their practices in the future. Ninety percent were highly enthusiastic about the role:

*Yes. We would. Definitely. And we are looking towards having more nurse-led type clinics and having HCAs that are highly trained and skilled. It would all help (#01).*

*Definitely. If we paid to the course I would say possibly but I would have to talk to (name) and to my other partners and listen and look at the costs. I think they have really proven their worth to us very well. They are not a receptionist. They are doing admin duties and they are doing a lot of clinical duties (#08).*

Possible future tasks for a PCPA

It should be noted that not all of the suggestions given would be acceptable to all doctors and the response might vary according to the type of use that the doctors had already made of the PCPA; i.e. the emphasis on the type of attachment that the PCPA was given.

- A telephone specialist.
- A prescription specialist.
- A surgical assistant capacity.
- Lifestyle screening.
- Basic hands on for dressings, suture removal.
- Collate new patient assessment forms.
- Health screening.

The future of the scheme

The main themes from this question were all positive and have illustrated the potential of the position in primary health care. These are summarised below.

*It will work well but perhaps not in smaller practices (#01).*

*It makes economic sense. We are not getting more GPs or nurses (#02).*

*Promising. I cannot see enough GPs (in the future) (#03).*

*Fantastic scheme. I think it would be of use in a small practice. It makes us efficient and there are cost benefits (#06).*

*I would be very happy for it to keep going (#10).*

Conclusions with reference to the GPs’ responses to their survey

The GPs showed a high level of enthusiasm for the project with only one showing moderate enthusiasm. There was some reluctance to commit to paying course fees, but a large percentage stated they would
employ a PCPA again in training. Only 20 percent (later 30%) \(^{14}\) felt that their own work load had been decreased. Sixty percent said there had been little difference in the workload. Review of this showed that the benefit was related to the PCPA being attached to the GP.

The attachment of the PCPA to the GP (as opposed to the nurses and/or the receptionists) was the key factor in the GP having more time for special interests, more time in the consultation and in the difference made to job satisfaction, with the exception of one practice where the PCPA was full-time with the nurses. However, in this practice the GP said if the nurses were happy, s/he was happy.

Eighty percent of the GPs were of the opinion that the quality of health care had improved since the advent of the PCPA; 60 percent thought that the practice health targets and nursing targets (40%) had improved.

**Practice nurse interviews**

**Effect of the PCPA on the position of the practice nurse**

The perceived effect as measured by the practice nurse of the impact of the PCPA on their position varied significantly. The size of practice did not appear to be a determinant. From the accounts of the practice nurses it was clear that realising the potential of the PCPA role within the practice structure was an important factor. In addition, having the freedom to employ the PCPA exclusively in this role was a significant difference in determining the effectiveness of the role within a practice.

For interview questions see Appendix 8, page 63.

In one practice the possibilities of the PCPA role were recognised but the person selected has been found to be not entirely suitable for the role. Meanwhile the enthusiasm of the management team for developing someone in this role in the future was not diminished. In another practice the PCPAs are assigned for a large part of the day to work alongside a specific doctor so the impact on the role of the practice nurses has been minimal. Against this kind of background there is little uniformity between practices as to the effect of the PCPA role on members of the practice team, specifically nurses. This may help in part to explain the difference in responses of the practice nurses interviewed.

<table>
<thead>
<tr>
<th>Table 6: Effect of PCPA on PN position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Significant effect</strong></td>
</tr>
<tr>
<td>50%</td>
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</table>

While the table may not at first glance present a picture of significant impact of the role of the PCPA on a practice nurse, further investigation revealed that the reasons for that can be attributed to factors related more to the actual practice rather than to either the PN or PCPA.

In the reported minimal (40%) or uncertain effect (10%), the effect was on the GPs’ time as the PCPAs worked one on one with a doctor. In another practice there was ongoing restructuring including changing medical staff and dynamics which constrained the work of the PCPA. In the third example, clearly the wrong decision was made in the selection of the candidate to fulfil the PCPA role; while a number of nursing tasks had been delegated to the PCPA in the first instance, gradually those had been taken back as the person did not meet expectations. Lastly in one practice the expectations of staff appeared to be at odds with the reality of the role that a PCPA could fill, and their need was in fact for someone in a registered nurse role.

These examples are in sharp contrast to the views expressed by 50 percent of the nurses in the following quotes where in one case changes were made in practice processes to incorporate the role of PCPA to free up members of the practice team:

*In terms of the nurses she now does all the results...we implemented a system when she started so the doctors send through the result...they are coded i.e. either urgent, needs to be seen in 24hrs or seven days – they can come in at anytime. She (the PCPA) rings or sends out a letter, so basically delivers all the results (#06).*

Here the changes have released nurses to do clinical work:

\(^{14}\) This practice changed the use of their PCPA during the programme.
The days she is at Uni in two hours we would have 30 phone calls on the nurses’ phone...it has changed because when patients previously rang they would get an answerphone...now they get a person – they love having someone there. In terms of service it has made a huge difference. It also means because she has not got a clinical background the calls can be shorter so there is a lot less productivity time spent on the telephone. She can say you need to discuss that with your doctor (#02).

For a list of the effects on the nurses see Appendix 9, page 64; and for a list of the tasks delegated to the PCPA see Appendix 10, page 65.

Release of time for the nursing team

Although the hope had been to assess exactly how much extra time was created for the nurses through the PCPA role only three were prepared to venture any time and that was tentative. The tables in appendices 9 and 10 show that significant time is available because of the PCPA for nurses to concentrate on clinical work. The quote below supports such a contention:

Our administration work is crippling plus the nurses don’t like doing it and the other thing is with that administration work, if a nurse sits at a computer in the nurses’ office and does it, she is then pulled out from that to do clinical stuff...it is hard to have nurses sit in an area just to do tasks...if the PCPA sits there she doesn’t get pulled away in the same manner. The boundaries are a lot clearer. It is easier for her to sit there and do the work than for a nurse (#02).

In this practice the entering of data following a nurse’s consultation with a patient had, in part under delegation, largely been handed on to the PCPA. The PN also spoke of the awkwardness of a nurse sitting at a computer in full view of patients from a busy waiting area entering essential information but the more acceptable ‘look’ when the PCPA does that task.

Several practice nurses felt that a very positive result of the PCPA taking on tasks was a significant reduction in patient waiting times as evident in the following quotes:

I don’t know that we provide any additional services but certainly I would like to think it is cutting down on patient waiting time. When we are busy you may have five people waiting to see a nurse and there may be some simple things like having their BP checked, before they pick up a script or similar (#05).

So in this case the PCPA was directly contributing to the reduced waiting time by checking a blood pressure, whereas in the next example the work of the PCPA had taken some pressure off the nurses to allow them to offer what they considered a ‘better’ less rushed service to patients:

The PCPA has allowed us to do services we actually deliver better...we are not being rushed...waiting times have gone down so we have been able to do new patient checks...ideally in the long run would like to get the PCPA to do (#04).

Then below, another example of a practice process being modified to realise the potential of the contribution a PCPA can make:

I am restructuring, separating the phone out so the PCPA … does the script phone… all the rest of calls to triage nurse (#06).

While such a modification may sound insignificant, it is not when one considers this is a newly-merged practice with 200 enrolments a month at moment… and understandably facing considerable challenges with the merger of staff in new premises and a rapidly growing population.

Evidence of nurses working at a higher level

Forty percent of the nurses described undertaking new tasks and 20 percent stated that they had increased the number of nurse-led clinics, including increased attendance at clinics as the PCPA was able to ring and remind patients of their appointments. Fifty percent, however, had noticed a large reduction in paperwork and 30 percent a slight reduction.

The nurses were asked if they had increased the amount of preventive care. To this the reply was that 50 percent had increased and 50 percent had noticed no change.

Uncovering concrete evidence of nurses working at a higher level in statistical form is not easy but it was obvious from the majority of practice nurse interviews that they consider the PCPA role had played a part in them being able to work at a higher level.
Please refer to Appendix 11, page 66, for further clarification. The table shows from the PN’s point of view examples of the way that the PCPA role has had an effect on new tasks, nurse-led clinics, paperwork reduction and preventative care. A selection of quotes below suggests anecdotally that this is happening.

I think the PCPA role supports nurses working at high level because they are not being dragged down doing those admin tasks… when stuff is sitting there and they can’t get to it is very frustrating… now they can get out there and do clinical work so it frees them up (#10).

The following statement was made after describing the way PCPAs had been able to take over tasks the RNs were doing and so freed them up to put more time into nurse-led clinics:

I think the nursing clinics are far more productive because now they’ve (RNs) actually got the time to fill them, and that’s definitely shown… we do COPD and diabetes and they’re much more full and we are getting up there with our targets. I think the other thing is they’ve been able to spend much more time with each patient because they’ve got more time, they’re not being rushed… so I think it is more patient focussed and a lot more prevention… so I mean it’s been a big thing (#9).

Some practices were already working at a high level as can be seen in the following quote:

We do most of the punch biopsies here; we do calcium infusions… all the IV cannulation and IV antibiotics (#2).

The quote below includes a long list of tasks taken over by the PCPA that RNs would usually do and gives some idea of the workload lifted from them, which obviously would allow them to operate at a higher level:

If my PCPA was staying… I would be getting an additional PCPA so there would be two of them full-time every week so they would basically have a week on the phone and the other would do restocking, recalls, autoclaving, new patient checks… they would swap in and out because have found that EN and PCPA both got very burnt out on the phone… one of those things you need a rest from. Other tasks would be setting up lab packs, urine collections, entry for smear taking, mammograms (#4).

In another practice a purely administrative task once done by the nurse is now done by the PCPA:

Another thing she does in the morning is scan through the templates and if there are any nurses off sick or any issues she notes that and if there are any double-bookings able to notify patient well in advance and sort it out before patient gets here (#2).

A number of procedures carried out in this practice have prerequisites prior to the next stage of treatment, and having the PCPA check that these are completed means that the nurse or doctor can go through the checklist in the certain knowledge that there will be no hindrances to the procedure they need to do:

The other thing she does is make sure a six-week check been booked for a baby coming in for a six-week immunisation… a lot don’t go to Plunket now… things like that that make things run more smoothly (#2).

Practice nurses’ own job satisfaction

Sixty percent of the nurses had noted either an extreme or improved increase in job satisfaction. The immediate and emphatic response of one practice nurse to the question of job satisfaction was:

Oh yeah, it’s huge! It’s been really hugely beneficial. I think what it has done is give people more defined roles… yeah definitely, and the nurses are a lot happier too because they are over doing all these things and were complaining to me as to why they have to do all this rubbish… you know… when they’re nurses, they’re not computer girls, they’re here to nurse! … But I think just talking to them all in the beginning and finding out what they didn’t need to be doing and having that open communication within the team… and continuing that too… then you can just tweak the roles to make it work for you (#10).

Difference in quality of healthcare provided by the practice nurse

Most of the nurses who commented on this were of the opinion that the quality of healthcare provided by the practice had improved. One practice nurse used the example of being able to better address the needs of a particular ethnic group within the practice as evidence of improved quality of healthcare:

I think… because you can spend the time, and we can provide far more appropriate thorough care and I think address their needs… if you rush them they won’t take note of what you’ve told them, so you actually spend the quality time to
go through…and I think the quality of care has definitely improved a huge amount … the girls have got a lot more job satisfaction too…and I think that makes them a lot happier doing what they’re doing (#10).

Another nurse who stated that she did not think the “quality of care” had improved said:

Maybe no difference to quality but better service to patients because if the patient is waiting for BP or blood results, the PCPA can take them aside and do BP, lab forms etc…it complements the work of the RNs (#4).

**Assistance from the project manager/clinical co-ordinator for the programme**

One hundred percent of the nurses were of the opinion that the project manager had provided valuable support to them during the programme.

Several of the practice nurses alluded to the necessity of having someone in the role that in this demonstration is called the clinical project manager. Firstly, the support and encouragement provided by regular visiting and talking with each PCPA in their practice environment was essential, on the one hand to check on the tasks they were doing and on the other to guide and advise on the academic side of the PCPA course. For most PCPAs it was their first foray into study at university level and the stress that induced was remarked on by a number of the practice nurses. They were grateful for the input of the project manager in that respect:

She (the PCPA) moans about the assignments sometimes but you know that’s normal with students! I think having that basic support… when they started off… how to be at university and how to write assignments, that background stuff was very useful because, as you say, a lot of them haven’t even done anything…they’re completely thrown in that field… they are not academically minded, so they really need that support (#10).

Practice nurses not only appreciated the opportunity to speak with the project manager/clinical co-coordinator about how the programme was going, but also to know that they were supported in their mentoring role with the PCPA:

It’s been really good…I think they definitely need that support…and also them touch base with you to see if you’ve got any problems and vice versa (#10).

** Appropriateness of training provided by the tertiary programme provider**

The teaching given by Unitec and AUT was seen by 80 percent of nurses as being appropriate:

*(They have) given good insight and overall perspective (#6).*

*Some skills are irrelevant to practice and a waste of time (#9).*

*Been challenging for young PCPAs with academic work alongside full-time employment (#4).*

*Needs to recognise an ECG abnormal rhythm (#10).*

*Provides great content and is diverse (#5).*

*Needs more exposure to clinical skills and experience (#2).*

**Recommendations for the future of the position**

There was a lot interest from practice nurses about the future of the PCPA course and questions asked about the way it might run. There was some concern that there may be a full-time course which would make it difficult for practices to release people for that length of time. One day a week was manageable, although in practices with more than one PCPA that could prove challenging.

One PN spoke of her experience:

*It has been my pleasure to help my PCPA develop in this role and then see whether she wants to do more of the nursing side or the administration side (#4).*

All but two of the PNs would be willing to take part in a further training programme. Of the two who were “probably” and “reluctant yes”, one said she would only take a PCPA for administrative work and the other wanted there to be more clinical training. One of the affirmative nurses suggested that the academic training should be in the form of block courses of a week each.
The idea of having the PCPAs as an accepted member of the practice team prior to embarking on the PCPA course was seen as valuable by several interviewees and is expressed in the following quote:

…having them train in the practice beforehand: It gives them the drive too and actually they’re your staff so you will actually look after them and nurture them too…and also the benefits of the training come back on to the practice…and also to see the person develop and grow…she was also a brilliant worker but now she’s got more drive and she’s got the understanding behind it and the critical thinking, you know you can just see it clicking in her mind ‘so then this person’s got this,’ you know she keeps going back to the pathophysiology to see why this is happening…so I think that’s a really big thing (#05).

In one practice where the PCPA has intentionally been used in a largely administrative role, the PN suggested that the course could provide an opportunity for such a role:

I could see this as a fabulous avenue for practice managers, administrative staff, medical receptionists…because nobody teaches you …in small practices receptionists do other things (#01).

I really like the idea of the position and of the other practices where doing more clinical work…I really like the idea it is unregulated. Because I am so busy I think my nurses would find it difficult to have direction and delegation responsibilities if role more clinical…because we have shifts and nurses not always working with the same person and have students too so I am not sure how it would work in this practice (#07).

Another interviewee said:

The ideal workplace is a size where they can get the work experience and they can have the supervision, and they need people who want them to be there too (#03).

One practice nurse considering the big picture said:

I’m very pro the PCPA programme. I saw it when it first got started in hospitals. I can see the possibilities… I think having them on board has definitely helped the whole team unit …but I think it’s a big question: how to bring it out to those practices that haven’t had it and how to bring it out…there’s the whole education side …do you put them straight into the practice or do you just give them a little time or do you bring them back and forward… or rotate around a few different practices to learn from a big one to a small one …so they can learn the different ways (#01).

Other tasks that could be developed in future

- The PNs suggested that under their supervision PCPAs could potentially do the following tasks15:
  - Plastering.
  - Phlebotomy.
  - ECGs.
  - Inhaler technique.
  - Simple wound dressings.

The nurses’ view of the future was that the training needed to be flexible to match the changing needs of primary care practice and to meet the needs of each practice. Ongoing discussion with the medical and nursing staff about the needs of practices need to be included in the development of any new programme. As one nurse said:

…if most of them are clinical then maybe that is where need to tailor the package (#10).

Mine do phlebotomy now. They take bloods…I always think about plastering, whether plastering techniques is a good one…and they’ve also shown interest in that…we work quite differently to the ones in the city….definitely plastering is one that I’d like to bring into the role…with regular training and updates and that support with them (#4).

Perception of the role of the PCPA

Eighty percent of the RNs expressed high enthusiasm for the role. One RN was moderately enthusiastic and one was conditionally enthusiastic. So overall there is high affirmation for the PCPA position:

[I have] High enthusiasm. I love it! As I say I can see a huge need for them and I think it just helps with the whole team and you are delegating roles out, but it’s for the benefit of the whole team, they provide support for everybody really, they’re not just for the nurse, for the whole team and that’s where they need to be developed…I think communication’s the biggest thing…finding out what your staff want and having a medium in the middle and set job descriptions (#06).

15 Note that some practices are already doing these procedures and others will not allow their PCPA to do them.
[I have] High enthusiasm. I’m all for it, I think it’s really good and you can give them responsibility and they take it on board really well… I think it does depend on the person… there’s plenty of support for them here. … everyone seems to get on really well. I think because we are a practice which takes on nursing students and doctor students we are used to… teaching and guiding and doing all sorts of things… everyone seems to pull their weight and help out. High enthusiasm … I see it certainly has a place… if I had more room which I had hoped for I would have had two triage rooms and a nurse room that the PCPA could do height, weight and measurement and make sure the dashboard all good before they see the doctor… would be a really nice way to do it (#02).

Practice manager interviews

There was a high degree of enthusiasm for the PCPA role from 90 percent of the practice managers. See Appendix 12, page 67, for interview questions.

Time factors for practice managers

The PMs were questioned on their estimation of the time that the PCPA had saved them and their estimation of time saved for the GP and the practice nurse. It was evident that PMs considered that the PCPAs had minimal influence in the reduction of their work load. Any reduction in administration was attributed to a reduction in nursing administration.

Estimation of work load relief for other staff

Doctors’ time reduction

When questioned about the time saved by the PCPA for GPs the responses varied from an estimation of 10 minutes an hour to minimal. This depended on the type of use the GP made of the PCPA.

They do triaging16 and screening of the patient who presents to the GP so it means that it is reduced time for the doctors that do blood pressures, weight. Blood tests are followed up and are perhaps ordered before they go through to the GP. There are a number of those types of activities when the patient presents for their appointment with the GP. They have all the blood results there, the scans and x-rays and that type of activity. (Do you think this enables the GP to see more people in the available time?). I think they can definitely get through them faster. Most of the preparation work has been done. (What about the number of people seen in a day does this affect that?). Definitely. Ours see a minimum of six (an hour) and our service definitely makes things easier. It also makes things easier for them to focus on the cases (#04).

Other PMs felt that there was minimal effect on the GP’s time. This was usually reflected in the increased time that was saved for the nurses.

Probably minimally but when you think everything filters down, she does jobs which would have been done by a nurse and it probably has a slight effect. She has the job of chasing up jobs which would normally have been done by a nurse (#05).

16 Note use of the word triage to indicate pre-consultation preparation by PCPA.
Nurses’ time reduction

The PMs, in contrast, when asked about the time the PCPA saved the nurses were overall enthusiastic and the responses indicated that the nurses were saved a large amount of time (mainly nursing administration) which allowed them to be more clinically involved. One practice manager reported that there had been a considerable benefit to both GPs and nurses as the PCPA had relieved both doctors and nurses from paperwork and administration.

_They have reduced the workload of doctors and nurses. It is a waterfall type effect – nurses and doctors have given patient and paperwork to the PCPA and nurses have picked some of the doctor’s work. This allows both doctors and nurses to spend more time with patients, health promotion, etc_ (#09).

One hundred percent of the practice managers stated that extra time had been created by the PCPA for nurses to perform other work.

Meeting health targets

An estimation of the PCPA contribution to reducing health targets showed that 50 percent of PMs reported that improvements to meeting health targets were due to the PCPA role. Two PMs did not know if they had achieved their health targets and two stated that their health targets had always been good. One practice which had had a big improvement stated that was due to the combined efforts of the staff and the PCPA:

_[We] Didn’t meet health targets in 2011 but we did in 2012 and are on track for 2013. This is due to all staff members working hard on these; but the MCAs [PCPAs] give us that extra time_ (#09).

Only one practice manager was able to provide financial information of changes. She had figures for the first half of 2013 which showed a payment of $3,000 for meeting or exceeding health targets.

Practice population

Sixty percent of the practice managers described an increase in the number of registered patients in the practice; 20 percent described no increase in practice size, 10 percent did not know and 10 percent (n=1) were unable to give an answer as the practice had recently amalgamated with another. Only 20 percent of those who reported an increase felt it was due to the PCPA. The remainder considered the increase was due to a natural increase.

Effect of the PCPA on staff

One hundred percent reported that there was a positive effect on the staff with 20 percent of those reporting better integration:

_I think we have a better integration of the team compared with originally. We have always worked as a team environment and having a practice assistant there are areas which are much better, where you are now aware of_
various charges for things are used in the practice and what can be claimed and the understanding of the practice management system has improved and they can take the information further (#01).

Seventy percent of the PMs considered that the nurses were working at a higher level:

*I think it is a really positive one. They are clearly recognised and included in the nursing team and I think the nurses enjoy having the ability to do other things (#05).*

**Practice manager’s estimation of changes to services**

The PMs were asked for their estimation of any *increased services* provided by GPs and nurses and to whom were they offered. In addition they were also asked for information on any extra nurse-led clinics. Half of the PMs reported that the main advantage was the extra consulting time released by the PCPA:

*Basically they make sure the patient is in the room and the details are on the screen, (about) what they have come to see the doctor. They put a little message in MedTec. The patient is here to see you about the “blah blah”. This saves the doctors a huge amount of time. It is organised and documented on screen in MedTec what medications they want today (#02).*

*I think when they need to; they are able to spend more time with the complex cases. I think also it has taken a lot of pressure off them to have to work really fast and perhaps the quality drops then. The GPs are far happier (#04).*

**Types of additional services provided by the nurse**

Ninety percent of the PMs reported that the PCPA had allowed the nurses to give additional services, such as extra nurse-led clinics, followed by services to chronic patients (some PMs chose more than one option).

![Extra services offered by nurse](chart.png)

However, half of the managers considered that the nurses were able to do more independent work. Interestingly, where the extra services were provided by the nurses, there was usually little or no increase in the services provided by the GPs.

In one practice the advent of the PCPA allowed them to free up 12 appointments in a week for nurse-led funded clinics and also time to place un-booked walk-in patients with a nurse to avoid referral to the local A and M clinic.

Eighty percent of the PMs strongly affirmed that there was an overall reduction in paperwork for doctors and nurses.

**Financial considerations of a PCPA in the practices**

**Business case for a PCPA**

The practice managers were asked to consider if there would be a business case for employing a PCPA. Ninety percent believed this was the case.

Ninety percent of the PMs had a business case prepared for the employment of a PCPA and 70 percent
reported that they would employ another student in training. Thirty percent would pay course fees and a further 40 percent reported that they “probably” would.

Evidence of the portability of the role was clear with 80 percent of PMs willing to employ a qualified PCPA from another practice; 20 percent said they probably would.

Summary of the responses of the practice managers

Fifty percent of the PMs stated that the PCPA had not provided any reduction in their own workload and 20 percent considered that there had been very little reduction in their load. Further quantitative information is shown in the sample taken from the single day survey of the work by the PCPAs (which was conducted by the PCPAs themselves), where the time spent by the PCPAs assisting the PMs was 6.8 percent of their time. This included a stand-out PCPA who spent just under four hours on that day relieving the PM (40 percent of her time). When compared to the 2-3 days survey, three PCPAs stood out with 79, 58 and 31 percent of their time taken up for the PM.

The practice managers were not well informed about the amount of time that the PCPA saved the GPs. Thirty percent estimated that perhaps 10 minutes per hour was saved. This was expected to be reflected in the number of GPs who had the PCPA attached to them (n=3). When the times for the PCPAs on the one-day sample were analysed, only one PCPA spent a significant time with the GP (#15) and this amounted to 69 percent of her time. The others were very much less. Other PMs (20%) were unable to quantify the time saved by the GPs and the remainder considered it was minimal or did not know.

One hundred percent of the PMs stated that extra time had been created for the nurses but were unable to quantify the amount. This would be confirmed in the one-day survey of PCPAs where all the PCPAs spent time with the nurses, although in widely varying amounts. Extra confirmation of this is contained in the 2-4 day survey, with the exception of the data for PCPA #2 who spent no time during that survey with nurses.

Health targets were generally thought to have improved and 50 percent of the PMs stated this was due to the presence of the PCPAs.

Practice populations had increased during the time of the program in 60 percent of the practices but only 20 percent of the PMs considered this was due to the PCPA. The balance was of the opinion that this was due to a natural increase in the population.

The perception of the effect of a PCPA role on the staff in general was 100 percent positive with 20 percent of those specifying that better integration had resulted. Seventy percent considered that the nurses were working at a higher level. The PMs also considered that the GPs had more time for consulting and were able to spend more time on complex cases. The GPs themselves said that they had more time to spend on special interests such as minor surgery, circumcisions (cultural), dermatology and a special interest in ophthalmology. The nurses were able to conduct extra clinics and concentrate on chronic patients, men’s and women’s health and to deal with the walk-in patients.

There was a reduction on paperwork for both doctors and nurses; a small increase in the preventive work done by nurses and; the GPs workload either reduced or more patients were able to be seen. In all the above the ‘don’t know’ category ranged from 10 to 40 percent.

The financial considerations of having a PCPA in the practice were contained in whether there was a business case for a PCPA; future employment of a PCPA in training; whether the PMs would be willing to pay the course fees of a PCPA and whether they would employ a trained PCPA in the future. In these 70 percent would employ another PCPA in training. The numbers in favour of paying the course fees fell to 60 percent (yes or probably) but rose to 100 percent (yes or probably) for future employment of an already trained PCPA.

When the future of the scheme and the enthusiasm for the scheme were discussed, 80 percent considered it was a good role and fitted well within a primary health care team. Ninety percent expressed high enthusiasm for the scheme.
Limitations

Demonstration programme limitations

The response to the introduction and roll out of the PCPA programme and the overall positive reception it has received from staff within general practices where it has been implemented, gives no hint of any significant limitations of the programme. The only obvious limitation at this point appears to be that the combination of courses from two institutions provided logistical difficulties and not having one qualification at the end of the programme did not provide a clear career pathway.

Evaluation limitations

There were limitations to the evaluation which were outside the control of the evaluators.

Firstly, the evaluation was required before the end of the programme. The effect of this was that the full competencies of the trained PCPAs were not able to be examined. As this was a developing role, not only were the PCPAs not fully trained or competent, and some medical and nursing staff were not fully utilising the role, but PCPAs were out of the practice one day per week for study. There is consequently no post-training evaluation to assess the consolidation of training and learning. As there has been considerable development during the demonstration programme in the ability of the PCPAs to participate in the health care of patients, it would be important to see if learning and development is sustained.

Secondly, access to financial information was sparse. It was anticipated that interviews with the general practitioners in the demonstration programme would provide information to document the financial benefits of employing a PCPA. A demonstration of the proposed questions showed that this was not correct. While general practitioners gave information about changes to their health care delivery and could discuss their level of satisfaction with the role, they had no evidence of the actual time released or the financial impact on the practice. As practices are privately owned and operated or in a trust, some information was commercially sensitive and the evaluation team was not in a position to require information to be available. In addition, most GPs interviewed were not involved in the development and management of financial records, and most of the practice managers did not have access to detailed information able to be readily analysed.

Thirdly, practices were integrated with all staff contributing to the financial outcomes for any practice. It was rare for the effects of any staff member or role to be responsible for a particular financial outcome. Direct GP payments could be identified but even these increased or decreased for a variety of reasons not directly attributable to any particular staff member or staff role. Similarly, the outcomes for practice targets were attributed by practice managers to be influenced by a total staff effort, except in one practice where the PCPA was reported to have sole responsibility for patient recalls which released the nursing staff to run more clinics. The additional role of a PCPA was reported as having contributed to the overall outcomes.

Fourthly, the patient sample for the satisfaction survey was limited to those patients who had had contact with a PCPA. Thus any patient who had declined involvement with a PCPA was not invited to participate. In addition, there is no information on the number of invitations that were made. These factors may have influenced the strength of the positive responses.

Fifthly, not all PCPAs were given the opportunity to provide a practice-wide service as the intention of some practices was to have them confined to one section of their trained competencies. Although there was compliance with the requirements of the demonstration programme for PCPAs to become proficient with the set tasks and skills, three PCPAs were predominately working in reception and/or administration. Having had extended education, some of the PCPAs felt limited in their employment opportunities when they were not employed in a flexible practice-wide capacity.
Discussion

The programme for training the Primary Care Practice Assistants was developed and marketed as a generic training programme to develop a flexible position specifically for primary care, to enable the person to work across the whole practice; administration, reception and clinical. Practices chose to weight the role towards one or more of the areas. However, some practices have been very focused on how they want their PCPA to be working, with some PCPAs assisting the nurses, some allocated to assist a specific GP and some concentrating on administration and reception.

More than half of the PCPAs came from a position within the practice and these were all from reception and administration. Most of these trainees had been competent and satisfied with their job description. There were three unexpected outcomes due to this. The first was that some PCPAs found that the tasks that they had previously been responsible for were not completed on their study day and there was the expectation that this would be completed on their return. The second was that the clinical skills/tasks of the programme were given little opportunity for practise and consolidation and thirdly, some PCPAs prefer to remain only in one aspect of the role.

The international literature shows that a similar role in the USA has two strands to their training programmes (US Bureau of Labor Statistics, 2011) – an administrative/reception training and a clinical training strand. This may be an avenue worth exploring in the future.

The flexibility of the role is both a strength and a weakness. One of the unintended consequences of the training has been that some practices are now losing some very capable staff members who have been captured by the extension of the education they have been exposed to in this programme and who are now moving on to full or part-time training as a registered nurse. Those practices committed to workforce development, especially for Māori, have welcomed and supported this move. Other practices have balanced the role between two or all of the role dimensions and have welcomed the ability for the PCPA to be able to move between administration, clinical and reception as necessary.

In large part what has made this programme so successful has been the supportive role through the programme of a clinically experienced project manager. For nearly all of the trainees, the programme has been a major challenge, as it was their first experience of tertiary education. For those PCPAs who had not previously worked in the primary health setting there was an additional need to upskill in computer skills and managing patients. It was suggested by all PCPAs that there be more time allocated in any future programme to a preparatory section of the programme to learn Medtech, Endnote and academic writing. In addition, through the programme all PCPAs asked for more opportunity to practice the clinical skills being taught.

Funding for a number of doctors who did not participate in the programme appeared to be a major issue with the belief that if it had been funded there would have been greater uptake. While some of the practices in the demonstration programme would be willing to contribute again to the training of a PCPA because they were convinced of the benefit to their practice, there were others who were not so sure. Evidence of this is that only some of the practices paid for their PCPAs on study days. Having an NZQA-recognised qualification may attract a student loan if necessary and reduce the financial pressure on prospective future students.

The strength of support for a PCPA coming from the existing practice workforce has been valuable but a previous employment role can also limit the ability of a trainee to be involved in areas different from that original role. Some patients initially found it confusing to understand the change in role; e.g. from a receptionist to someone with clinical skills. Some practice staff took time to understand the effects of the change.

The programme has already been shown to provide a marketable strand of the health workforce as all GPs were comfortable with employing a previously trained PCPA and one said he would happily “poach”
The structure of the academic programme around one day a week within an employment position on a practice has strengths and weaknesses. The strengths for a PCPA are that there is a staff commitment to ongoing supervision to develop competency in any skill, learning opportunities are continuous and that the individual skills and preferences are recognised in work deployment. In addition, the exposure to new ideas and information from the tertiary courses has the opportunity to be consolidated. Particularly for students who are in tertiary education for the first time, the weekly support has been influential in the 100 percent retention in the programme.

Employment within a practice has an added aspect. Socialising a PCPA into a team is important in small working environments. The weaknesses are that there are competing tensions for students in full-time employment and with families in committing to an academic course. The addition of this further commitment has been reported by students as stressful.

The experiences of students who are in a placement rather than employed by a practice would be very different. However, a combination of employment with paid or unpaid leave for two weekly block courses could be the most optimum structure for the future.

One issue is the compatibility of the PCPA with the total workforce is if s/he is to be involved in all aspects of the primary practice. In the demonstration programme there was no 360° formal feedback from the practice staff. This would be a useful addition, as communication and the ability to work in teams is an important aspect of a primary care practice team.

There are two aspects of safety which need to be considered in any ongoing programme development. The first of patient safety is paramount. While there have been clear directions for PCPAs to work only under direction and delegation, during this training programme, in any unregulated position there needs to also be an understanding by clinical staff that the responsibility for the actions of the PCPA reside with them. All practices had a staff member who attended a Direction and Delegation session; see Appendix 13, page 68.

The second is a safety issue for PCPAs who are under no legal protection. The nurses’ organisations have discussed these issues and all agree that there needs to be appropriate parameters within which a PCPA is able to work. In addition, the NZNO recommendation that Health Care workers shall be supported to access ongoing training and refresher courses to support their role and that the HCA be included in practice meetings and quality initiatives (NZNO Practice position statement. 2011, p.5) is something PCPAs have considered important for their ongoing development.
Conclusions

All of the innovation goals of the demonstration programme have been satisfactorily implemented and accomplished.

There was considerable evidence that all the practice staff interviewed were highly positive about the beneficial effect of the role in their practice and considered the innovation project to represent value for money. Patients were highly satisfied with the service the PCPAs provided. The primary care practice assistants also reported high levels of satisfaction with the training programme and their own jobs.

The project team continually responded to concerns or issues which arose both in the development of the programme and the implementation. It was not possible in the time available to develop an academic programme specifically for the PCPAs, and the innovative collaboration between two institutions provided a wide curriculum which incorporated levels 4 and 5 courses, which were inspirational for some students and difficult for others. The personal and academic support of the project manager/clinical co-ordinator was critical to the successful outcome for students.

No negative outcomes occurred.

Commonalities across sites and identification of any distinctive features

Commonalities

There were very few commonalities across the sites in the number of patients, number of doctors, number of nurses, practice population or practice modus operandi. There was also little common utilisation of the role of the PCPAs in general or between multiple PCPAs in any one practice. Although the PCPAs had the same basic skill learning, and most did some basic patient measurements, the use of those skills depended on the needs of a practice. In practices with more than one PCPA, each PCPA had a particular role. For example, in one practice, one PCPA did all the pre-recordings, pre-appointment work with patients, and assisted with minor surgery; the other PCPA did all of the autoclaving, some pre-appointment work but no minor surgery assistance. In another practice where the PCPA worked with GPs, the allocated tasks depended on the requirements of each particular GP. In all practices with a PCPA with special prior training such as phlebotomy, these skills were utilised. This flexibility of the PCPA role was a strength of the programme.

The commonalities relate to: satisfaction with the role of the PCPA, the programme support, the academic outcomes of the students, the efficiencies within the practices, the provision of quality care and the increase in either the numbers of nurse-led clinics or increased attendance at these clinics:

- PCPAs reported a high level of satisfaction expressed about their employment. Eighty-nine percent (n=17) were satisfied or highly satisfied. Ninety-five percent (n=18) found the “on the job training” to be good or excellent.
- Ninety-three percent (n=18) of PCPAs stated that they would recommend the course to future students. One PCPA said a recommendation would depend on the proposed course development.
- One hundred percent of the PCPA students were satisfied with the attention given them during the course by the project manager/clinical co-ordinator.
- Ninety-six percent of the patients (n=174) were highly, or very satisfied with their contact with the PCPA.
- One hundred percent of practice nurse mentors were highly satisfied with the support given by the project manager/clinical co-ordinator in her role as clinical tutor to the PCPAs.
- The previous educational status was on the whole not high. Only one PCPA had a tertiary qualification (BA). One student had a polytechnic diploma and another two had attended a polytechnic but did not
claim a qualification. The remainder had varying degrees of secondary school achievement.

- All courses to date have been passed by all students. Notification of the final semester grades were not available at the time of report submission.

Given the lack of post-secondary school qualification held by these trainee PCPAs, the academic success of the total group of students is a very satisfactory outcome.

Distinctive features of the programme

There were several significant features in the development and implementation of the programme:

- Most of the PCPAs were already a member of the practice team and so they were known and trusted.
- Comprehensive Health Ltd employed a senior and experienced registered nurse with 15 years’ experience in clinical tutoring for a nurse training tertiary programme as the Project Manager/Clinical Co-ordinator. This had the added advantage of involving a person well known to the health profession in the Auckland area. As a clinical tutor, the project manager was able to support the PCPAs through their courses at AUT and Unitec and also within the practices. Nurse mentors in the practices were able to trust the project manager to ensure a high level of clinical and professional standards and to ensure issues of safe practice for both patients and PCPAs. Her position was also supportive for the nursing practitioners in general.
- The development of a programme across two institutions was novel and necessary for the development of a complete programme in a very short time. Making use of existing courses fulfilled the need for some broad education but was not wholly successful in engaging some of the PCPAs, who initially struggled with the higher level of learning required. In contrast, this exposure to a higher level of academic exposure motivated three of the PCPAs to decide to further their education through a nursing degree in 2014.
- Offering the programme from two different institutions on the same day presented a logistical problem as the travel between the two campuses added stress for several students. In addition, the teaching style of the two institutions differed considerably, with one offering courses to very large classes and the other to more informal smaller classes. Without the project manager/c clinical co-ordinator’s presence and support, some students would have found this extremely difficult to manage.
- All PCPAs were employed in practices. This is an important feature of the programme as it requires the support of practice staff in training the skills necessary for competence in the role. This may reduce the number of practices who wish to be involved, as a commitment to in-practice teaching is an important requirement. The difference from any other health-related course was that a PCPA had always been working in the practice and not perceived as supernumerary and thus was not recognised as being in training, at least by patients. It was important for them to be identified by a uniform or badge to delineate them from other health professionals particularly when engaged in clinical tasks.
- A practice nurse mentor was recruited in each practice. These nurses were senior experienced nurses, some of whom had tutoring experience. This was a critical position as she was responsible for supervision of PCPAs and in-practice teaching. The level to which the practice mentor had time available to provide this supervision was variable as it was not specifically designated time out of her own practice.
- Although this programme required competency in a number of clinical skills, the project manager/clinical co-ordinator emphasised through the courses, tutorials and in-practice training that the PCPAs are obligated to work under “direction and delegation” in order to provide safe practice.
- The PCPA position was designed to prepare students for an across-practice role. The flexibility it offered was that each practice is able to utilise the PCPA to the advantage of the needs of any particular style of practise and any particular need. In addition, individual PCPAs were able to utilise their personal strengths and prior experiences as appropriate. Practices were very variable in the use they made of the common skills and tasks in which PCPAs had to be competent by the end of the programme.
- Where a practice was innovative and offering increasing opportunities for preventive medicine, the availability of a skilled PCPA fitted well. For example, in one practice; a practice car was used to transport patients to the surgery for recalls, health checks and specific nurse-led clinics, and the PCPA assisted a registered nurse to run rheumatic fever reduction clinics in schools.
- Students in this demonstration programme have been financially supported by HWNZ through the payment of course fees, and by practices which have made a financial investment in staff development.

17 Addendum: Eighteen of the 19 PCPAs completed the course successfully.
18 Courses at AUT will not be available in future.
by whole or part-payment for the weekly study time out of the practice. Note that some practices have asked for a two-year return of service for this financial support.

- The demonstration programme has been externally evaluated from the beginning.

Lessons learned about the establishment and implementation

Recruitment

Recruitment to the programme resulted in 19 PCPAs in training in 13 practices. The recruitment process was prolonged, despite using a variety of advertising practices including the use of local and professional news opportunities, personal written, telephone and face-to-face contacts with practices and PHOs and responding to all expressions of interest. Although the lack of interest in the Auckland area resulted in the catchment being widened to include practices in the Northland PHO, those who became involved had at least one GP or practice manager in each practice who was positive about the opportunity. As the programme progressed, staff attitudes to the position had changed in the practices with a working PCPA, to the extent that both doctors and nurses who had been ambivalent about the additional role were highly enthusiastic to have a PCPA either in training or qualified.

In practices declining to be involved, the response by nurses and/or doctors was initially negative or the role was seen as impracticable due to space or financial constraints.

All of the avenues for the establishment of a programme were identified and utilised. A further rollout of the model may benefit from the information available through professional word of mouth and the exposure to the information from this evaluation.

Implementation of the programme

The programme was well constructed and ran very smoothly. Having the project manager/clinical co-ordinator in practices frequently, provided the opportunity for any issues to be discussed. There were few operational issues and these were minor. The end of programme interviews with practice staff showed very high levels of satisfaction with the implementation.

The training in the role was standardised through a job description, four tertiary courses and clinical tutoring in the practices. The project manager has been a pivotal person in ensuring that this occurred by weekly engagement with the students on the weekly study day and by visiting each Auckland practice fortnightly, Northland practices monthly in the first year, and three-weekly for the third semester. This was designed to support students who were academically weak and to assist with the development of good organisational skills. In addition, the regular contact gave opportunities to be responsive to questions from practice staff and to deal with any operational issues.

The programme comprised one course specifically developed for this new position:

- The PCPA course was developed to focus on training the skills to provide support across a primary care practice.
- One existing level four generic course designed for health care workers, and
- Two existing Level 5 courses

Within these courses the project manager/clinical co-ordinator negotiated for the inclusion of some specific components to existing AUT and Unitec courses in order to ensure that the contents of the courses were applicable to the needs of the position of a practice assistant in a primary care setting. In addition, the presentation times for AUT and Unitec assessments were dovetailed to reduce stress for PCPA students.

This demonstration programme as a whole does not have NZQA accreditation. A certificate is provided for completion of the PCPA course from Unitec and from Comprehensive Health Ltd for completion of the PCPA programme of study including all courses. Certificates of Proficiency (COPs) from the two courses at AUT can be utilised for cross crediting to higher qualifications.

In addition to the formal training and education, in-practice learning occurred. The involvement of practice staff in mentoring was variable, from scheduled fortnightly opportunities to discuss issues, to
requested supervision for practising skills and for information regarding levels of normality for particular tests. This in-practice teaching was provided by both doctors and nurses. It is important to consider that all PCPAs were employed in the practice and staff were committed to ensuring the best training for their student.

Programme delivery

As the tertiary education programme was conducted in Auckland, students from Northland had considerable travel time each week. Both practice staff and students, in Northland in particular, would have preferred to have had block courses as they found it difficult to provide cover for one day a week out of the practice.

A description of operational issues and possible solutions

With the flexible use of the PCPA role in practices, one of the issues is to ensure standardisation of the course. The present model with a clinical tutor has ensured that the course focus has not been compromised. The nurse mentors were experienced senior nurses, many of whom already had experience as a preceptor in a registered nursing programme; but this is not necessarily universal in primary care practices. Not all primary care practices are engaged in the education of undergraduates; either nurses or doctors. It is important that practices engaged in any future training programme have a registered practice nurse who has been involved in ongoing education with undergraduates.

In the future development of the PCPA programme, it may be desirable to have specific educational opportunities for prospective nurse mentors to ensure quality education for the trainee PCPA and that the scope of their practice is not breached.

Different expectations of practices through individual job descriptions resulted in some PCPAs not becoming confident in one or more aspects of the programme. This was particularly evident for those practices which weighted the employment time towards administration and reception. Clinical skills may have been taught and accomplished sufficiently to be “ticked off” in a practice but were not utilised frequently. A solution for this may be to encourage practice nurse mentors to make sure that important clinical skills are regularly supervised and practised.

There was concern by some nurses at the increased scope of tasks required by other practices and differences of opinion in what was reasonable to delegate/allow PCPAs to engage in. Given that PCPAs are under “direction and delegation” and that as health care assistants, they are legally accountable for their action and accountable to their employer (Nursing council of NZ, 2012), it is important that practice staff delegate within the PCPA trained role/job description (Principles of delegation 1b and 1d).

In making a decision regarding subsequent implementation, it is important to give consideration to the differences between new practices educating an existing staff member, and attracting a specific person to fill the role. The experiences of practices in the current programme have been that it takes time to, firstly, socialise the role into the practice; secondly, for existing staff to trust a new staff member to delegate PCPAs to tasks; and thirdly, to identify an existing staff member as having moved to a different role. For staff members in the demonstration practices to understand the role and how that would impact on their own role took up to six months for some practices.

The development of new skills required more practice than was available through the course opportunities. All PCPAs suggested that future courses include time for supervised practise with other PCPAs and course tutors.

Barriers and impediments to making required changes to the regulations and subsequent implementation

Currently there are no regulations for the position of PCPA, and at present the regulatory status of the programme is similar to that of a Health Care Worker (HCW). A HCW is governed by the rules and guidelines of a DHB and the job description for the area in which they work. Each HCW has a generic job description with extra tasks and duties applicable to the specific area of employment. Apart from a DHB four-hour annual update of CPR and safety, HCW have no programme of ongoing education, or funding
for such a programme.

Similarly, a job description guides PCPA practice in any practice. It was the intention of the programme that tasks were completed under direction and delegation of a doctor, nurse mentor or practice manager. For clinical tasks PCPAs are expected to be working only with stable and predictable patients and have directions to refer back tasks which are outside their trained competency to the appropriate doctor or nurse. Several PCPAs reported that they would like further education in specific areas and at the discretion of each individual practice. The PN’s in general were very positive about their role of PCPA oversight and teaching. The unregulated status of the PCPAs was not perceived as a barrier to providing quality health care.

The programme is not a recognised NZQA qualification as discussed previously. Currently, although each institution will provide an academic record comprising a certificate from the HCW course, certificates of Proficiency (COPs) from AUT and a certificate of programme completion from Comprehensive Health, this latter certificate is not a stepping stone to further education. The two level 5 courses may be accepted by AUT as part of the nurse training programme, but it is important that in the future the programme be considered within a pathway for a further qualification.

It is the intention of the developers of the programme to provide a full level 4 course for consideration by NZQA, which would provide a stepping stone to a full nurse training programme for those who wish to take their education to a higher level.

**Evaluation of patient experience**

Patients were almost universally positive about the interactions and assistance from a PCPA. All of the questions were open questions and it was interesting that the comments covered goals embedded in the development of the programme.

There was little understanding of the scope of the role, so that comments and ratings were based only on individual contact. The reports from patients need to be considered with an understanding of the limitations of the purposive sample. The acceptance of seeing a PCPA in part depended on the way in which the staff of the practice perceived the role and of patients’ acceptance. Thus there were no comments from any patient who knew of the PCPA role but did not accept their services.

The role was accepted as providing an efficient process for patients that reduced or ameliorated their waiting time. The pre-consultation experience was reported in two ways. Firstly, by making a patient feel valued and cared for and also for helping the doctors and nurses to concentrate on higher level tasks. Secondly, the personal qualities of the PCPAs, such and being informative and friendly, gave patients confidence to see the PCPAs again in the future. Patients liked being able to talk to a person (PCPA) on the nurses’ phone rather than leaving a message and waiting for a return call.

The issues of safe practice were identified, with some patients commenting that the PCPAs knew their limitations, which confirms the intention of the teaching directives.

From the survey there was a clear indication that patient acceptance for the role of a PCPA in primary care had added quality to the care provided and no safety issues were identified.

**Changes to the efficiencies generated by the model being trialled (potential and achieved)**

Changes in the ways in which practices were benefitting from the addition of PCPA to the staff of a practice were evident from the second half of the first year of the demonstration. At this stage there were general comments from practice nurse managers and practice managers that:

- The practice was working better.
- Practitioner satisfaction was higher.
- The patients were attended to more quickly.
- Patients were highly satisfied with the service.
- Patient records were up to date and complete.
- Nurses were able to focus on working in the more complex health areas.
• Initial screening was more complete.
• There were benefits to the practice with more targets being met.

General practitioners

One GP had changed his/her attitude from being ambivalent to the role, to requesting to be allocated one of the PCPAs to assist him/her, and by the third semester other GPs in practices had started to work directly with PCPAs – if the PCPAs had time to do so.

GPs had more focused consultations with a PCPA having completed the basic measurements and pre-consultation assessment.

General practitioners who had allocated time with a PCPA were more likely to have additional or advanced services in the workload and reported that they were able to:

• See more patients in an hour.
• Spend more focused time with their patients.
• Manage their paperwork within a working day rather than after hours.
• Develop special interests such as minor surgery, cultural circumcision, ophthalmology and dermatology.

Practice nurses

There was no evidence of role substitution by a PCPA. Rather, there was a positive response to being able to focus on professional rather than on practical and paper-based administrative tasks. Sixty percent of the nurses interviewed said their job satisfaction had increased because they had a more defined role and were not spending time on non-nursing tasks. Boundaries were clearer and their nursing time was not being diminished by being pulled away to attend to administration or telephone work. The PCPAs have enabled nurses to work at a consistently high level by taking some of the load from them - paperwork (which covers a whole range of things), administration, answering the phone, cleaning, autoclaving, assisting in theatre, etc - things which fell to the nurse to do because there was no one else to do them.

Evidence of the changes to the nursing roles included:

• More preventive care (50% more for one clinic).
• More productive clinics.
• Larger diabetic and COPD clinics.
• More patient-focused practice.
• More time for consultation due to a PCPA pre-nurse-consultation work up.
• Better able to address the specific needs of a particular ethnic group.
• More appropriate care for specific ethnic groups.
• Seeing more patients.
• Releasing a second registered nurse from assisting with plastering.
• Better performance on primary care targets (e.g. smoking cessation and asthma clinics).
• More time in patient education.
• More time to see patients opportunistically.

For one practice where the nurses were already working at a high level, the advent of the PCPA who was mainly employed in an administrative role, the changes that have happened because of what the PCPA does, have been very significant. She had enabled the nurses to be consistently working at a high level and to see more patients, and not have to spend large blocks of time behind a computer entering data, because she is doing that for them.

Some PNs were already planning to increase the number of PCPAs employed and had a range of specific tasks to allocate to them, such as having a new script line as well as a line to triage patient needs. Others were considering using PCPAs for assisting with plastering, phlebotomy, ECGs, teaching inhaler techniques and simple wound dressings.

Those practices which had an enrolled nurse (EN) reported a positive effect of releasing the EN to enable her to work at a higher level, which subsequently provided more clinical time for nurses at a higher level.

Practices have the flexibility to delegate a PCPA according to their job description, and not all practices
have the intention to extend the present role in the same direction. However, the project manager/clinical co-ordinator does not favour extending the programme to include further level 4 skills. There does need to be the opportunity for those PCPAs who wish to extend their level of competency in clinical practice to use their certification in the PCPA programme to move into training as a registered nurse.

**Practice managers**

PMs reported less effect on their workload from having a PCPA in their practice than other staff, although the records of a working day and of a 2-4 day workload showed that some PCPAs believed that they had assisted their practice manager for some considerable amounts of time.

The PMs have identified that non-quantifiable changes to their practice included a more integrated staff, greater job satisfaction in the nurses and the GPs who directly worked with the PCPAs, and the flexibility to fill in temporary staffing gaps.

**Quantification of the safety of the innovation**

There have been no safety incidents from any of the practices and no safety issues raised throughout the programme.
Recommendations

1. There is universal satisfaction with the role of a Primary Care Practice Assistant and it is recommended that the training programme is continued and expanded nationally.

2. That a job description, practice policies and protocols be developed to define the role and function of a PCPA as there are many variables in the role.

3. The provision of a session on the requirements for safe direction and delegation as outlined by the Nursing Council needs to be available for all practice staff in a mentoring position for trainee PCPAs.

4. Future training programmes should be under the jurisdiction of one tertiary institution and submitted to NZQA for accreditation.

5. Future training programmes need to be flexible with blended delivery to meet the needs of rural and distance learning.

6. Future programmes need to retain the in-practice teaching components with students and staff supported by a clinical co-ordinator.

7. An initial block course to introduce students to academic writing, referencing, Endnote and Medline would assist students who are in tertiary education for the first time.

8. Dedicated opportunities through the course for supervised practice of new clinical skills need to be available to standardise competency.
Appendices

Appendix 1: Literature Review for Primary Care Practice Assistant

The role of the Primary Care Practice Assistant (PCPA) was developed by Comprehensive Care Ltd. (formerly Comprehensive Health Services) in association with Unitec and AUT to provide a demonstration of the role of the PCPA. The proposal was accepted by Health Workforce NZ. The new role is intended to free up the time of GPs, managers and practice nurses (Health Workforce New Zealand, 2011).

Twenty students were recruited to work as PCPAs across a range of GP settings, initially in the Waitemata PHO, but the range was extended more widely due to the difficulty in recruiting enough practices in the designated area. Routine administrative and clinical tasks were stated to be taking up valuable time of both GPs and practice nurses and the introduction of this role was seen to be able to allow these personnel more time to practice “at the top of their licenses”. The likely tasks that the PCPA would be required to do would include: administrative and clinical work ranging from assisting with nurse-led clinics; recording clinical measurements; treatment room preparation and other tasks as required. It was estimated that a full-time PCPA could free up 5-15 hours of a GPs time and 10-20 hours of a practice nurse’s time per week (Health Workforce New Zealand, 2011).

The position of PCPAs has been used in variable forms around the world under a variety of names.

The United Kingdom

The job description of a Health Care Assistant (HCA) appears to be the UK equivalent of the NZ PCPA and covers a range of skills which are similar to the NZ specifications. This document details the personal specifications that are desirable in a person who is contemplating such a career and the methods by which the specifications are assessed (Royal College of Nursing, 2012).

Petrova, Vail, Bosely and Dail (2010) identified the benefits and challenges of employing HCAs in general practice. Overall the HCAs were seen as a valuable addition to the primary care team, as they were found “to accelerate rather than extend services and allowed more appropriate use of nurses’ skills and enable cost containment” (p. 303). However, their training and supervision, particularly in the initial phases was found to be time intensive and demanded a significant commitment by nurses The authors stated that “the nurses reported having experienced concerns and had doubts worries and fears when an HCA was first employed” (p. 307). Alternatively some of the nurses felt that the employment of an HCA was long overdue. Overall the concerns were usually allayed over time but some anxieties persisted. On a few occasions there were some tensions between the HCA and administrative staff, especially if the HCA had originally been a member of the administrative or reception staff.

Where patients were concerned, Petrova et al. (2010) reported that there was general acceptance; although those with problems were those who expected the HCA to be able to do more than she was expected to. Some patients began to self-refer to the HCA.

Unintended consequences were described. These included: potential deskilling of other members of staff; changes in the nurses role which might become too intense with only the difficult jobs left for the nurse. No patient-related unintended consequences were reported by the authors.

Vail, Bosely, Petrova and Dale (2010) in reviewing the experiences of the HCAs in general practice found that they appeared to be satisfied overall, but that there were elements of dissatisfaction related to status, pay and career progression, which may have limited the retention of individuals in the role. This appears to have similarities to the study in the USA by Chapman, Marks and Chan, (2010). Vail et al. (2010)
also investigated the acceptability of the HCAs to patients. This was mainly positive and the acceptance improved over time. Of note was their finding that role boundary between the nurses and the HCAs appeared to be well defined and they had good working relationships within the practice, especially with the practice nurses.

A study examining the role of HCAs, in this case, of screening rates in colonic cancer, showed an increased referral rate (+123%) (Baker, Parsons, Donnelly, Johnson, & Day, 2009). The authors argued that the HCAs played a key role in increasing screening rates.

In a UK study across the general practices in one Primary Care Trust, Brant and Leydon (2009) described the rapid development of the HCA as occurring on an ‘ad hoc basis’. In addition it became apparent that the developing HCA role was largely shaped by the culture and requirements of individual practices, so was very responsive to local need. In this regard coupled with the ad hoc nature of implementation, Brant and Leydon claimed this was similar to the advent of the role of practice nurse.

Lack of education and training opportunities were seen by interviewees participating in the study as aspects which may hinder the development of the HCA role. Overall, teamwork and good communication and the effect of the individual nature of practices appeared to be the key determinants in the development of the HCA role.

As practice assistants are not uncommonly trained on-the-job and as such can be considered to be unqualified, Philip and Turnbull (2006) developed a training module which offered both theory and practice to help unqualified general practice assistants. Overall the participants agreed that this had strengthened their knowledge, added new skills, heightened their job satisfaction, added significant diversity to their role and enhanced their employability.

The aspect of concern relating to preparation and training and the HCA role is highlighted in a paper by Bosley and Dale (2008). The question of the HCA posing a threat to a nurse’s professional identity was raised and the implications such a threat might have on teamwork, quality of patient care and patient safety. They cautioned against taking evidence about the role of an HCA in a hospital setting and applying it to general practice, without taking into account the different context and activities. They also highlighted the varying cultures of practices and the close knit, relatively stable practice team and the effect of a new role entering that situation.

Bosley and Dale also drew attention to the difficulty of finding definitive evidence relating to the cost-effectiveness of the role. Indeed they concluded:

…increasing the skill mix in primary care can save GP time, improve patient access, and provide enhanced services without compromising patient care, but is not necessarily more cost-effective than more traditional models of care (p. 220).

Interestingly this evidence is similar to that found by Longbottom, Chambers, Reboara, & Brown (2006) in relation to practice nurses. Their finding from a large body of information which they described as “coherent rather than contradictory” was:

…that reviews concerning the substitution of doctors by appropriately trained nurses in patient consultations, as measured by a range of outcomes, resulted in the finding that the substitution was cost-neutral (p24).

In a study of healthcare assistants across two primary care trusts in the West Midlands by Vail, Bosley, Petrova and Dale (2010), aspects such as an individual’s previous position, experience and length of time working in the practice were found to be key influences on the HCA’s approach to the role. It was clear, too, from the analysis of interviewees’ responses that ensuring “protected time and resources for mentorship and career progression” was an important consideration for practices to take into account to further ensure future success of the role. In an earlier study, Spilsbury and Meyer (2005) underlined the need to better understand the HCA role in relation to the role of the RN and also stressed the important role RNs needed to play in “assessing HCA competence and in the supervision and monitoring of their nursing work” (p. 80).

The scope and definition of the HCA role is referred to in a number of UK studies (Andrews & Vaughan, 2007; Fletcher & Rush, 2001; Storey, 2005) and concerns existed about the lack of clarity as alluded to above. However, some also acknowledge that if such concerns are allayed the outcome for general
practice is positive because "the employment of HCAs is one way in which the potential skill mix within
the practice can be maximised, and demands on general practice met" (Andrews & Vaughan, 2007,
p. 623). In a climate in which there is increasing pressure on GPs to meet economic, demographic
and governmental pressure, the HCA role or New Zealand equivalent of the PCPA is surely a relevant
consideration.

The USA

In the USA the nearest equivalent to the PCPA role is that of Medical Assistant (MA), which is one of the
largest groups of support staff at community health centres (Blash, Chapman & Dower, 2011).

The MA is able to work in a variety of administrative and clinical tasks in the “offices of physicians (GPs),
podiatrists, chiropractors and other health practitioners” (US Bureau of Labor Statistics, 2011). MAs should
not be confused with physician’s assistants who examine, diagnose and treat patients under the direct
supervision of a physician. The system used in the USA divides the MAs into two main groups:

• Administrative medical assistants, whose task is to update and file medical records, fill out a variety
of forms and arrange hospital admissions and laboratory services. They can also perform less medically
orientated tasks such as handling correspondence, telephones and greeting patients.
• Clinical medical assistants, whose tasks vary according to state law in the USA. Some common tasks
include taking medical histories, recording vital signs, explaining procedures to patients, preparing
patients for examinations, and assisting doctors during examinations. They may also do laboratory work
and sterilise instruments.

Wilson, Fegan, Romence, Uhe and Dionne (2011) studied the opinions of the preceptors (teachers) of
MAs in the USA. Eighty percent of the existing certified MAs and 80 percent of the nurses reported that
the MA students provided the office with extra help and placed no financial burden on the practice. The
preceptors considered the students a beneficial aspect of the practice because they lightened strenuous
workloads and stimulated the preceptors to remain current in their professional fields.

The role of MAs was reviewed by Chapman, Marks and Chan (2010). They argued that the role of MAs was
increasing in small primary care practices. However, despite the significant role played by the MAs they
reported that there was little regulation of their practice, or standardisation of education, or certification.
In addition they found that there was a high turnover of MAs, and that little investment had been made in
the recruitment or retention of these staff. Lastly, they commented that the MAs had little opportunity for
a career ladder.19

Ferrer, Mody-Bailey, Jaen, Gott and Araujo (2009) investigated the effect of medical assistants on the
screening of patients with risk-taking behaviours. Their findings showed that although this produced a
significant increase (P > .001) in screening and referral, there was no corresponding increase in the results
of the intervention for the behaviour.

A more recent attempt to utilise the medical assistants in a constructive community role has been
undertaken by Willard-Grace, DeVore, Chen, Hessler & Bodenheimer (2013) in California. They intend
to use them as a resource to provide self-management support for patients with uncontrolled chronic
disease. This is to be conducted as a clinical trial.

Australia

In Australia medical assistants are trained to carry out delegated administrative and clinical assisting
duties specific to the ambulatory care environment (Anderson, Proudfoot, & Harris, 2009). The role was
first introduced into general practice in Brisbane in 2005. This was based on reports of work overload of
GPs and their nurses.

Widespread consultation with medical, nursing and other general practice-related groups was
undertaken in an attempt to dispel concerns about role substitution by medical assistants. An exhaustive
search of state and federal legislation was conducted. Initially the cost of the course and the large number
of face-to-face classes as opposed to on-the-job training did not translate into enrolment, and only

[19] There is as yet no national certification for the PCPAs in New Zealand.
small numbers of graduates resulted. All the graduates, with the exception of those who did not have English as a first language, gained employment. One practice reported that the MA’s skills were such that their MA was employed full-time in clinical duties. Other practices achieved the dual role of clinical and administrative duties.

Major findings of Anderson et al. (2009) were:

- The need to consult widely to gain clinician buy-in.
- The imperative to bring together health and education sector expertise.
- The need for flexible course delivery, such as self-paced and on-line delivery.
- The need for consumers and all members of the GP team to be educated regarding the boundaries of the MA role.

New Zealand

The situation in New Zealand has been described above. The PCPA program is still in the demonstration phase and is subject to evaluation. Two health-related organisations have commented on the program.

The New Zealand Nurses Organisation (2010) has expressed conditional support. They contended that the NZNO is not averse to innovation in service provision, but that safety of patient and staff is of paramount concern\(^{20}\). However, they expressed concern for the role of the registered nurse if delegation and supervision of the HCA in primary health is expected to come from the RN and not the GP. The NZNO provided a list of their recommendations and emphasised that the HCA must not make clinical judgments and must work under the supervision, direction and delegation of a health professional. A point of major concern to the NZNO was “the haphazard introduction of unregulated HCAs into health service” (p. 2)\(^{21}\).

The Royal NZ College of GPs commented on the introduction of the PCPA scheme as part of their commentary on the Physician’s Assistant trial at Middlemore hospital (O’Halloran, 2011). They stated that they would be keen to work with Health Workforce NZ in the development of new roles in primary care. Their view was that it should be a “non-clinical role” with the aim of freeing up nursing time for greater involvement in clinical activity. They anticipated a “knock-on” effect for doctors to be freed up for some tasks.

The College of Primary Health Care Nurses welcomed the demonstration of the PCPA scheme (Nursing Review, 2011). Their spokesperson argued that as HCAs were already “up and running” in some practices, the HWNZ demonstration would formalise the training requirements, policies and procedures required for the timesaving role.

A number of PHOs have established courses for a Health Care Assistant-type role to fulfil a particular need and enhance the care provided in their particular primary care environment. Some examples of these are detailed below.

The ProCare General Practice Assistant course is a Level 3 course of 14 unit standards, NZQA accredited and run in conjunction with the HealthEd Trust and appears to be completed in large part by correspondence. Those who complete the course receive a National Certificate in Health and Disability (see www.procare.co.nz).

A collaboration by Midlands Health Network and Wintec resulted in the launch in April 2012 of an 18-month demonstration training programme designed to support the role of medical centre assistant. Again the course has an online component and the student has a practice-based mentor along with input from a Wintec tutor. “Midlands Health Network provided input into the content and assessment criteria for the Primary Care Assistant programme, which consists of two qualifications. Successful students will graduate with a Certificate in Business Administration and a Certificate in Health Support Assistants; both are NZQA level 4 accredited” (www.waikatodhb.govt.nz/news/pageid/2145876709#sthash.FCDwwkVo.dpuf).

Western Bay of Plenty PHO in partnership with the Bay of Plenty Polytechnic has established a 60-credits Level 4 Certificate in Health Care with strands in advocacy. The course has been running for three years and has been well received by practices in the PHO. HCAs have contributed to improving performance

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\(^{20}\) Note that Petrova et al. (2010) reported no unforeseen consequences to patients.

\(^{21}\) It is possible that the introduction of the present PCPA scheme occurred after the NZNO produced their statement.
indicators for high need patients in the general practices in which they are employed. The course has also proved beneficial for other HCAs employed in residential care homes.

**Summary**

The role of the Health Care Assistant/Medical Assistant appears to be well established in the UK, USA and Australia. In New Zealand, the Primary Care Practice Assistant is in the evaluation stage, although in many practices this role has been in use on an unofficial basis. The literature has examined many of the potential unexpected consequences of the role and has found that concerns about this have not eventuated. Authors have given suggestions on the methods of introducing the role into practices to avoid the potential for role replacement conflict. Some authors have commented on the difficulty of evaluating the cost effectiveness of the role.

Overall the role of the HCA/MA has been well established in the international literature with minimal if any unintended consequences.

**References**


Appendix 2: Progress report summaries

Progress report 1: Summary

This evaluation showed that the demonstration project had been well considered and flexible enough to work well in any practice setting. It appeared to be an attractive option as a career pathway for a considerable age range of prospective applicants. Practices were required to pay for at least 16 hours employment in the practice; in addition some practices also paid full or part payment for the study day. The course fees were paid from the HWNZ Innovations Services to cover the academic and skills training at tertiary level.

The demonstration programme had been developed and initiated effectively through collaboration with the PHO and tertiary institutes by the programme developer and the project manager/clinical co-ordinator. The position of project manager/clinical co-ordinator was critical in mentoring the PCPAs and ensuring that they were able to complete the academic requirements of the programme and to have some standardised experiences in the practices. Given that the practices individually had their own clear and specific job requirements, this was an important aspect of the programme working well.

Recruitment

The recruitment process initially focused on the Waitemata area and was thorough and prolonged. Initially, contact included emails to Waitemata PHO practices and information regarding the demonstration in the Waitemata Weekly that all practices receive; a focus group was held. This produced five responses of interest. The scope was widened to include contact with 170 practices from a wider area which resulted in the involvement of 13 practices (19 PCPAs).

The barriers given for lack of involvement were:

- A lack of space for another staff member.
- Financial implications of having staff in training.

The majority of PCPAs (14/19) had already been working in some capacity at the practice which supported them into this new position. The practices which advertised for a new staff member to train for this position had a high level of response from the public. Three of these PCPAs came from an administration position and two had been employed as a healthcare assistant prior to joining the practice.

The low level of uptake from the original areas in central Auckland resulted in PCPAs from three practices (five PCPAs) coming from Northland and having to travel long distances to Auckland for the whole-day courses. In addition, because many of these PCPAs had been employed full-time in the practices and most had come out of reception or administration, this left gaps in the employment strength of the remaining staff. There were suggestions that future programmes should offer block courses, as paying for a full day of study was practically and financially unattractive.

Education programmes

The initial programme, which was set up for a total of 120 credits, with 90 credits at level 5 and 30 at level 4, was changed to a programme of study more suited to the level at which the PCPA would be working. This resulted in a programme of four papers with 60 credits at level five and 30 credits at level 4. AUT papers provided additional tutorials for the PCPA students. Given that the majority of the PCPAs had either no school qualifications or what would be the equivalent of a level one NCEA qualification, it is a credit to their commitment to the course of study and the support of the project manager/clinical co-ordinator that all except one student passed the first year set of course requirements.

Commonalities in settings

There were very few commonalities in the practices or in the PCPA prior experiences, with the exception that 11 PCPAs had been in a receptionist role in a practice prior to moving into a PCPA role. Eight
practices were in urban areas, three were both urban and rural and two were rural. Practice size ranged between 3,220 and 12,100 patients. Three practices had a high number of Māori patients and one was a Tongan practice.

The designated practice nurse mentors were satisfied with the way in which the PCPA role was working. None of the concerns which had been expressed about the potential deleterious effect of the PCPA role on nurses’ practice or employment were in evidence. Nurses accepted their role in training and mentoring and were positive about their involvement. Any difficulties which were experienced devolved from practices which were very specific about the tasks they wanted to shift to the PCPA and those which the requirements of the PCPA training required them to complete.

The practices had experienced no complaints from patients about the role and nor were there any reported safety issues with the PCPAs. Practice nurse mentors were confident that the PCPAs knew their levels of competence and asked questions when in doubt. Initial feedback from the practice nurse managers showed a high level of enthusiasm regarding the role.

Progress report 2:  Summary

This report included a review of international and national peer-reviewed literature to the end of 2012 and this augmented the proposed list of questions used in the interviews. It was clear from the literature that there were no unintended consequences of significance from the roles of health care assistants or medical assistants. Questions raised prior to the introduction of the above positions have been examined and were unsupported.

Interviews with PCPAs

The PCPAs in this current demonstration had differing work environments. Some were assigned to work with a specific nurse or doctor; or had a more general attachment to a practice with direction to complete tasks from one or multiple members of staff. The previous role in a practice or other workforce, the personality of the PCPA, the practice structure and staff numbers all determined how a PCPA was employed in any particular practice. Regardless of the setting, the role/s and responsibilities within practices showed great variation. Again, the part played by the project manager/clinical co-ordinator was seen as essential to the smooth running of the programme. The PCPAs were very grateful for the level of support they had.

Job description

Tasks covered a wide range of activities which included the required tasks of the tertiary programme enumerated on a list of practical skills which were part of the course requirements; and a list of tasks required by the practice in which they were employed. There was variation in the range of these extra tasks in each practice; dependent on the prior competencies of individual PCPAs, practice organisation and available space.

PCPAs were enthusiastic about their developing skills and increasing patient contact. Some PCPAs found it difficult to shed their previous role in administration to allow them to take on more clinical tasks and some practices complied with the learning requirements of the demonstration, but employed the PCPA in a narrow range of tasks. Staff were utilising the previous training of PCPAs to fit their particular practice needs and others created new tasks to extend the practice offerings; such as new patient assessments, the administrative side of B4 school checks and recalls.

Education

There was difficulty experienced by some of the PCPAs with the level five theoretical courses they were studying in the second semester. However, all except one passed both of these courses. One PCPA had to re-sit to complete. The PCPAs who had not been in a health practice or who had considerable travel to attend the courses found the programme more difficult to manage.

Supervision and support

All staff and PCPAs who were interviewed reported that the PCPAs were clear about their boundaries
and safety issues and that nurses or doctors were supervising and supporting them. All the clinical tasks, which needed to be checked by a registered nurse or doctor or which needed a decision to proceed, were referred on. There were no incident reports involving a PCPA in any practice.

Changes in the practice

Practice nurse managers and practice managers’ feedback was positive. Any staff who were initially sceptical or negative about this new position were now enthusiastic. Concerns expressed that there could be unintended consequences or deskilling of other staff in the scope of this position were not reported. There were initially problems with the delegation of roles, but as the PCPAs became more skilled they became more self-regulating or were under direction and delegation for much of the work they were doing.

Nursing staff considered their workload had reduced or was enhanced by this role and that their practice was working better; patients were attended to more quickly and patient records were up to date and complete. Practice managers reported that they had a more cohesive staff with an increase in patient numbers and targets being met. The new tasks which had been introduced related to a more proactive and educational role for health practitioners.

PCPAs gave evidence of the tasks they had released from the nursing staff which allowed nurses to work at the highest level of their professional ability. As the PCPA became more skilled, the list of tasks they could take on increased. The list of tasks additional to those required by the programme was comprehensive. There was a high level of job satisfaction.

Patient acceptance was reported as high, although there was some initial confusion when a PCPA had been previously identified as a receptionist or in administration.

With regard to the role of PCPAs in primary health care settings, the flexibility provided by training in all aspects of practice is important to acknowledge. In any practice the role is a developing one, as existing staff roles change and opportunities are developed for widening the scope of nursing and medical practitioners. Some practices focused the role on relieving all administrative tasks from nurses; others provided in-house training to augment the educational skills taught through formal education. Each practice varied the role according to the strengths of the PCPA and the needs of the practice.

There was discussion regarding the difficulty of bringing in an untrained new staff member to train in a practice. When the PCPA evolved from an existing member of staff, issues of trust were not a problem. In three cases it was difficult for the PCPA to expand her role to be available to all aspects of the practice. However, employing a mature person with no health care experience but with a lifetime of experience was also seen as being beneficial for a practice.

Trial analysis of financial benefits

A trial of the financial benefits in four practices was undertaken to calculate benefits by taking the hours a PCPA worked on tasks that would have otherwise been done by a registered nurse. This showed that it was most cost effective for a practice to release the doctors or highest paid nurses from lower-level tasks. Using a PCPA as a receptionist was the least effective use of her skills.

Calculating the financial benefit to a practice by increasing the numbers of patients seen by a general practitioner when a PCPA was directly attached to a GP was able to be calculated in one practice which reported increasing patient throughput by one patient an hour. Several practices reported that it was difficult to attribute any changes to patient numbers or an increase in meeting targets to any particular member of staff as there was a ‘whole practice emphasis’ on doing this.
Primary Care Practice Assistant Evaluation

Practice similarities and differences

Similarities
There were few similarities in the structure or size of practices, the employment history of the PCPAs or the ways in which they work in a practice. One aspect of the position was similar for the majority of practices; all except three PCPAs had been working in the practice prior to this demonstration programme. All except two of these PCPAs were involved in reception or administration or both. The exceptions were two women who had been previously involved in an aspect of health care in the practice.

Differences

Practice differences
The practice environments and structures differed widely. Registered patient numbers in practices ranged between 3,220 and 12,100 with an average of 6,512 patients. Two of the largest practices had a 24/7 service which attracted an estimated further 10,000 patients a year in addition to the registered patients. Two practices were rural, three were a mixture of rural and urban and the remainder were urban. Practices in the south of Auckland had more Māori and Pacifica patients than any other areas included in this evaluation. The practices in Northland had more Māori than the north-east of Auckland practices, who had the highest numbers of NZ European patients.

The majority of practices had one PCPA; but one practice had three, and four had two PCPAs. The most obvious difference in practices was in the way in which the workload of the PCPA position had been utilised and how tasks were delegated. This ranged from:

• An attachment to one particular doctor in the practice.
• Tasks delegated by practice nurse manager.
• Tasks delegated by practice manager.

Some of the PCPAs had set tasks which may or may not have taken most of their working week. Others had a central collection point (such as an in-tray) which was used to direct the PCPA to tasks which need to be completed. Most had some autonomy to respond to patient needs, and to nurses and doctors’ requests for assistance.

Student-related differences
Practices had different descriptors for their PCPA such as Medical Assistant, Health Care Assistant, Practice Assistant and Primary Care Assistant.

The ages of the students range from 19 to 57 with an average of 35 years. The median age is 39 years. There is one Māori student and two who defined their ethnicity as NZE/Māori. Two are Tongan with the remainder being NZ European or European.

Working hours in the practice
By the end of 2012 the range of hours worked by the PCPAs was between 18 hours and 34.5 hours with a median of 32 hours a week. Twelve PCPAs were working in a practice for more than 30 hours a week, two were working under 20 hours and the remainder were working between 22 and 28 hours. Where there was more than one PCPA in a practice there could be diversity in pay rates. The number of hours worked were not necessarily the choice of the practice but a work/life choice by the PCPA.

Entry educational attainment
PCPAs educational experience, while tending in the majority to be at about an NCEA year 11 level, included one student who has a Bachelor of Arts degree. Many of the students had completed community certificates in a range of areas and others had a wide employment history. The older students tended to have School Certificate as their highest educational achievement. This has implications for the requirements of this programme to assist students to engage successfully in higher education to tertiary Level 5. The experience for this group of students as at the end of semester 2 has been that all except one student has met the pass standards for all the papers. For most of the students this has been a major achievement.
Pay rates
The pay rates range from 14 dollars per hour to 22 dollars per hour with an average of $18.50 per hour. The median rate of pay was $18 per hour.

Differences in types of tasks given to PCPAs
No practice used the same job description for the PCPAs as any other, although all were initially given a sample job description; and no work day appeared to be the same. For some practices there was a clear preference from the beginning to employ their PCPA mainly in administration or reception or in clinical support. Other practices have evolved the job description and this is still a developing position, as the PCPA shows different levels of learning and experience.

Some practices have placed more weight on general or clinical administration and reception; others have a clear focus of assistance to nurses and still others have attached the PCPA to an individual doctor. Where there is more than one PCPA in a practice the strengths of each tend to be utilised so that the workload of one PCPA may be heavily biased towards clinical tasks and the other towards administration.

Summary
In agreement with the findings from international literature regarding initial concerns with the use of non-clinically trained staff in primary care, the information from this evaluation to date has clearly shown that there are wide-ranging benefits to having such a position.

Evidence from the PCPAs themselves and from the samples of practice managers and practice nurse managers has shown very positive support for this role. From all perspectives and with regard to all questions asked, there has been a unanimously positive response.

To date, the direct financial benefits of the role of the PCPA appeared to be minimal for those working in the non-clinical administrative areas, but there were some financial benefits from releasing nurses and doctors to work at the top of their professional capacity.

Appendix 3: Contract requirements

1. To document and evaluate the recruitment and training of up to 20 practice assistant roles using a standardised approach.
2. To document and evaluate the development and completion of a training package.
3. To document changes to delivery of services in primary care settings and to provide an analysis of time created for the practice assistant, general practitioner, practice nurse and practice manager.
4. To analyse the additional and/or advanced services provided in primary care settings.
5. To document patients’ views and understanding of the purpose and usefulness of the practice assistant position.
6. To provide a greater understanding of the possible scope of the practice assistant role (further tasks and responsibilities).
7. To clarify where the practice assistant’s role fits within health careers.

Specific evaluation questions

1. How was the innovation project implemented?
2. Did the innovation project achieve the desired outcomes?
3. Did the project team learn from the innovation project and make improvements?
4. Did the whole innovation project represent value for money?
5. Did the innovation project result in any unintended outcomes?
6. Should the innovation be generalised and spread?

This final report is to include:

1. A description of commonalities across sites and identify any distinctive features.
2. Lessons learned about the establishment and implementation to inform a wider roll out of the model.
3. A description of any operational issues that may be encountered and possible solutions.
4. Information regarding barriers and impediments to making the required changes to the regulations and subsequent implementation.
6. Quantification of the efficiencies generated by the model being trialled (potential and achieved).
7. Quantification of the safety of the innovation.
8. Recommendations about any legislative or regulatory changes required to enable the model to be implemented and extended.

Appendix 4: Patient questionnaire

AC Research Associates has been asked to find out from patients what they know about the new role of the Practice Assistant in this practice and how satisfied patients are with it. This is an anonymous survey.

As you have just been talking with a Practice Assistant you are invited to give your opinion on how you think the role is working. Is this the first time she has provided a service for you?

Please put a tick YES…………NO…………..

______________________________________________________________
Q1 Please give some examples of what the Practice Assistant does in this practice?
Q2 Would you be happy for a Practice Assistant to provide services for you again?
Please tick your answer.
YES…………Sometimes……………NO………………..
Please explain your answer.
Q3 Overall, how satisfied are you with having a Practice Assistant providing services for you in the practice? Please circle one number.
1            2             3             4              5              6              7
Highly satisfied                             Neutral                                  Highly dissatisfied
Q4 Write below anything else you would like to say about the role of the Practice assistant.
Thank you for taking time to give us your opinions.

Appendix 5: PCPA questionnaire

The interview was designed to cover four themes; the:
• Experience and satisfaction with the role of PCPA.
• Experience and satisfaction with the programme of tertiary education.
• Experience and satisfaction of the in-practice of supervision and training and
• Suggestions for the PCPA programme.

1. How satisfied are you with your job?

<table>
<thead>
<tr>
<th>Highly satisfied</th>
<th>Very satisfied</th>
<th>Satisfied</th>
<th>Neutral</th>
<th>Dissatisfied</th>
<th>Very dissatisfied</th>
<th>Highly dissatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>6</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>
2. Has this role worked out in the way you expected?  
   *If no, please explain further.*

3. Are you able to work to the full level of your competencies? Or are you restricted in the areas you work?  
   *Probe to see where this applies e.g. restricted to paperwork or reception)*

4. What is your understanding of the attitude of the practice nurses to the role you are fulfilling?  
   *Please give examples.*

5. What tasks have you taken from the nurses?  
   *Please identify them.*

   What tasks have you taken from the receptionists?  
   *Please identify them.*

6. Have you taken on any tasks which are a new task/innovation in the practice?  
   *Please list.*

7. What is your rating of the teaching programmes at Unitec and AUT?  
   Excellent  Good  Neutral  Not so good  Poor  
   5  4  3  2  1  
   *Please explain the reasons for your rating.*

8. What is your opinion of the on-the-job training given by the practice?  
   Excellent  Good  Neutral  Not so good  Poor  
   5  4  3  2  1  
   *Please explain the reasons for your opinion.*

14. What types of support and supervision do you receive (if any)?
   • By doctors.
   • By practice nurses.
   • By the clinical tutor (by name).

15. How might the training for this (PCPA) role be improved?

16. Please tell us of any difficulties that have arisen during your training so far.

17. How is safety assured in the practice? (For you and for patients)

18. What are your employment or training plans for the future?

19. What (if any) opportunities do you want for ongoing education once this programme as finished?

20. How could the programme as a whole improved?

21. Where do you see the role going?

22. Is there anything else you would like to say?
Appendix 6: PCPA one-day participation chart

<table>
<thead>
<tr>
<th>PCPA #</th>
<th>Relieving nurse</th>
<th>Assisting GP</th>
<th>Relieving receptionist</th>
<th>Relieving practice manager</th>
<th>Lab Tests</th>
<th>Hours claimed for a day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>270</td>
<td>120</td>
<td>6.5 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>400</td>
<td>25</td>
<td>7.58 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>247</td>
<td>172</td>
<td>6.98 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>395</td>
<td>5</td>
<td>8.66 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>184</td>
<td>330</td>
<td>9.06 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>227</td>
<td>295</td>
<td>8.7 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>280</td>
<td>60</td>
<td>6.83 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>240</td>
<td>13</td>
<td>5.96 hours</td>
<td>55</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>43</td>
<td>250</td>
<td>9 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>323</td>
<td>230</td>
<td>5.38 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>195</td>
<td>20</td>
<td>5.41 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>61</td>
<td>59</td>
<td>6.51 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>78</td>
<td>261</td>
<td>7.23 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>206</td>
<td>111</td>
<td>6.73 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>281</td>
<td>25</td>
<td>7.93 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>408</td>
<td>30</td>
<td>7.83 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>420</td>
<td>30</td>
<td>7.5 hours</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>4258</td>
<td>1012</td>
<td>1781</td>
<td>300</td>
<td>80</td>
<td>123.85 hours</td>
</tr>
</tbody>
</table>

Appendix 7: General practitioner Interviews

Questions were divided into eight broad categories:

- Time factors for GPs.
- Doctors work style.
- The doctor’s estimation of job satisfaction and quality of health care.
- Financial considerations for doctors.
- PCPA employment.
- What future tasks could be developed for PCPAs.
- What the doctors saw for the future of the scheme.
- The doctor’s perception of the role of the PCPA.

Workload

1. How much do you work with the PCPA?
2. How has the PCPA been able to reduce the load on you?
3. How many hours a week do you estimate the PCPA has freed up for you?
4. What has changed in the range of things that you undertake with your patients?
   - What are you doing now that you did not do before?
   - Are you able to see more acutes/walk-ins?
   - Are you able to spend more time in consultations?
   - Are you able to spend more time attending to:
     - Chronic patients.
     - Men’s health.

23 PCPA #4 and #5 did not return the survey
• Women’s health.
• Special interests (define).
5. Has the PCPA made a difference to your job satisfaction? (how etc)
6. Has the PCPA made a difference to the quality of healthcare you provide? (how)

Finance

We are looking at financial implications of having a PCPA
7. Can you estimate how the PCPA has made a difference financially to your practice income? And/or are you able to see more patients in a day?
8. What health targets are you meeting that you could not meet before? 2011 - 2012 Does this produce financial benefits?
   Can you quantify this?
   Any other targets that the nurses are doing.
   Does that give financial benefits?
9. Would you employ another PCPA student in training?
10. Would you be prepared to pay the course fees for one of your staff to train as a PCPA?
11. Would you employ another qualified PCPA?

Conclusion

12. What other tasks could be developed in the future for a PCPA?
13. What do you see for the future of the scheme?
14. Overall what is your perception of the role of the PCPA?
   High enthusiasm.
   Moderate enthusiasm.
   Conditional enthusiasm.
   Not enthusiastic.

Appendix 8: Practice nurse interview

The questions were divided into 10 broad categories
• Effect of PCPA role on position of the practice nurse.
• Release of time for nursing team.
• Evidence of nurses working at a higher level.
• Practice nurses’ own job satisfaction.
• Difference to quality of healthcare provided by practice.
• Assistance from clinical project manager/clinical co-ordinator for the programme.
• Appropriateness of training provided by tertiary programme provider.
• Recommendations for future of the position.
• Other tasks that could be developed for the PCPA.
• Perception of the role of the PCPA.

1. What effect has the position of the PCPA had on your position?
2. What extra time has been created for the nursing team?
3. What additional services have been provided by the nursing team?
4. What evidence can you give me of nurses working at a higher level?
5. Can you quantify any changes in the level of paper work the PCPA has taken from the nursing team?
6. Have there been any changes to the preventative work nurses are able to do?
7. Has the PCPA made a difference to your job satisfaction? Please explain.

8. Has the PCPA made a difference to the quality of healthcare that you provide?

9. What was the most valuable assistance the project clinical manager (Comprehensive Health contractor) contributed to the programme?

10. In your opinion did the tertiary programme provide appropriate training for the PCPAs?

11. What recommendations do you have for the future of this position?

12. What other tasks could be developed in the future for a PCPA? Please list.

13. Overall, what is your perception of the role of the PCPA? (High, moderate, or conditional enthusiasm; or not enthusiastic)

Appendix 9: Summary of effects on practice nurses

<table>
<thead>
<tr>
<th>PN</th>
<th>Summary of effect</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Significant delegation of tasks</td>
<td>Filing, invoicing Care Plus patients, data analysis, National Immunisation Register details, contacting people by phone/email on behalf of PN</td>
</tr>
<tr>
<td>2</td>
<td>Uncertain of effect</td>
<td>BP's if nurses agree, also height, weight, ECGs</td>
</tr>
<tr>
<td>3</td>
<td>Delegation of tasks</td>
<td>High health user cards, mammogram recalls, Depo recalls and associated admin, smoking demonstration, miscellaneous recalls</td>
</tr>
<tr>
<td>4</td>
<td>Effect minimal</td>
<td>Working one-on-one with GPs</td>
</tr>
<tr>
<td>5</td>
<td>Effect not significant</td>
<td>PCPA was delegated tasks by PN but taken back as inability to fulfil.</td>
</tr>
<tr>
<td>6</td>
<td>Effect not significant</td>
<td>Potential of role seen initially but stymied due to practice dynamics and ongoing practice restructuring</td>
</tr>
<tr>
<td>7</td>
<td>Significant</td>
<td>PCPAs able to do mundane jobs – answer nurse’s phone, take messages and enabled nurses to do emergency work, recalls</td>
</tr>
<tr>
<td>8</td>
<td>Significant</td>
<td>Nurse’s phone, autoclaving, chaperoning, assist minor surgery</td>
</tr>
<tr>
<td>9</td>
<td>Insignificant</td>
<td>Assists some documentation but mismatch between PN’s expectations of role and what PCPA able to do</td>
</tr>
<tr>
<td>10</td>
<td>Significant</td>
<td>Reduced burden on nurse</td>
</tr>
</tbody>
</table>
## Appendix 10: List of tasks delegated to the PCPA by the practice nurse

<table>
<thead>
<tr>
<th>PN</th>
<th>List of tasks delegated to PCPA</th>
<th>Estimate of released time (all estimates by researchers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Respondent (as relatively new to role) unclear as to new tasks delegated</td>
<td>Doctors see one more patient each hour as result of PCPA</td>
</tr>
<tr>
<td>2</td>
<td>Recalls of smears and mammograms Monthly cleaning of autoclaves Data entry for new patients</td>
<td>Intangible – hard to measure</td>
</tr>
<tr>
<td>3</td>
<td>Repeat scripts Organising visiting phlebotomist to homes Completing high user card applications Does things which nurses would have done</td>
<td>Unable to quantify time released</td>
</tr>
<tr>
<td>4</td>
<td>Phones patients with results Send out letters with results Answers the nurses phone Filing Invoicing Data analysis National Immunisation Register Phones hospital to obtain discharge summaries and copies of lab results</td>
<td>Hard to estimate the time, but like having short of a nurse on the days the PCPA is away. Savings in nursing employment hours is 16 hrs per week at least as a result of employing PCPA</td>
</tr>
<tr>
<td>5</td>
<td>PCPA is working for the doctor in preparation of patients for consultation (BP, height, weight, other) Manages vaccine ordering Does practice recalls</td>
<td>Unable to quantify time</td>
</tr>
<tr>
<td>6</td>
<td>Requisitions high health user cards Mammogram recalls Other recalls including for contraception Smoking cessation demonstration management responsibility</td>
<td>Probably 20 hours saved in nursing time per week.</td>
</tr>
<tr>
<td>7</td>
<td>PCPA is working for the doctor in preparation of patients for consultation (BP, height, weight, other) Reception duties Cleaning Sterilising of instruments Assisting with minor operations Urinalysis, pregnancy testing Escorting patient from waiting room prior to consultation</td>
<td>Intangible – difficult to measure</td>
</tr>
<tr>
<td>8</td>
<td>Ordering of stock Taken over tasks all done previously by enrolled nurse Assisting in theatre Sterilising instruments Assisting with plastering (previously required two RNs) Escorting patients to radiology and laboratory Data entry</td>
<td>Hard to put a time on it All jobs are those previously done by a RN</td>
</tr>
<tr>
<td>9</td>
<td>Recalls Assists with wound care Minor surgery Data entry Preparation of rest home residents prescriptions Data entry related to rest homes Answers nurses’ phones</td>
<td>Unable to quantify</td>
</tr>
<tr>
<td>10</td>
<td>Urinalysis Pregnancy tests Practice management (previously receptionist) BPs, weight, height</td>
<td>Unable to quantify</td>
</tr>
</tbody>
</table>
## Appendix 11: Evidence of nurses working at a higher level

<table>
<thead>
<tr>
<th>PN</th>
<th>New tasks</th>
<th>Nurse-led clinic increase</th>
<th>Paperwork reduction</th>
<th>Preventative care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sees people more opportunistically</td>
<td>Increase in number of patients attending practice as result of PCPA – reminders etc</td>
<td>Huge reduction in administration Factory visits for immunisations no longer require two nurses but uses PCPA</td>
<td>Spending more time on patient education Increased CVD assessments, increased cervical smear rates</td>
</tr>
<tr>
<td>2</td>
<td>Spending more time on nursing activities</td>
<td>Clinic is more productive as RN has time to do COPD, diabetes, and performance on primary care targets is improving as a result. Increase in number of CVD clinics, and more attending.</td>
<td>Less paperwork</td>
<td>More patient-focused, more time for prevention</td>
</tr>
<tr>
<td>3</td>
<td>PCPA described as ‘useless’; and delegated roles have had to be taken back</td>
<td>Disappointing outcome</td>
<td>Slight reduction in paperwork, PCPA does recalls for immunisations, smears, mammograms</td>
<td>No change</td>
</tr>
<tr>
<td>4</td>
<td>No new tasks, but reducing patient waiting time as simple tasks can be done by PCPA</td>
<td>More time spent with patients, no clinic increase</td>
<td>Yes - PAs loading smoking cessation data on to patient records. No longer does patient recalls</td>
<td>No increase</td>
</tr>
<tr>
<td>5</td>
<td>More new patient checks done</td>
<td>Recent merger of practices No effect on clinic increases</td>
<td>Made huge difference to paperwork for RN Practice would like to get two PCPAs instead of one RN (opportunity offers)</td>
<td>PCPA doing more telephone answering, releasing enrolled nurse to do pre-employment checks, immigration medicals, flu vaccines and smoking cessation (raised her position to near RN).</td>
</tr>
<tr>
<td>6</td>
<td>None</td>
<td>None</td>
<td>Some</td>
<td>No change</td>
</tr>
<tr>
<td>7</td>
<td>More time to concentrate on clinical tasks</td>
<td>Drs able to see more walk-ins. No increase in nurse led clinics, but not as pressured as previously Drs have more time with patients</td>
<td>Does ACC claims Significant reduction in general administration in practice</td>
<td>More time for smoking cessation and asthma clinics</td>
</tr>
<tr>
<td>8</td>
<td>None</td>
<td>None – have lost funding for B4School checks to Plunket (not related)</td>
<td>Reduction in paperwork, including data entry for new patients</td>
<td>No apparent change</td>
</tr>
</tbody>
</table>
Appendix 12: Practice manager interviews

The questions were divided into eight broad categories:

• Time factors.
• Meeting health targets.
• Practice population.
• Practice manager’s estimation of services.
• Workload of GPs and nurses.
• Financial considerations of a PCPA in the practices.
• Perception of future and role of PCPA.

To increase the spread of the interviews, some practice managers were interviewed who were in a practice where no GP was interviewed (see practice manager interviews, page 35).

Questionnaire

We are looking for evidence of any economic benefits or practice changes through having a PCPA.

1. Has the PCPA been able to reduce the load on you?
2. What extra time has been created for:
   GP
   PNs
3. What extra additional services have been provided by:
   GP
   PNs
4. What are they doing now that they were not able to do before?
   • Are they able to see more walk-ins?
   • Are they able to spend more time in consultations?
   • Are they able to spend more time attending to:
     • Chronic patients.
     • Men’s health.
     • Women’s health.
     • Special interests.
     • Nurse-led clinics.
5. Can you give me the practice patient numbers for 2011 and 2012 to estimate any change in patient numbers. Is some or all of that due to the role of the PCPA?
6. Did you meet all your health targets in 2012? Did that differ from 2011? Can you quantify the financial benefits (from that)?
7. What effect has the position had on the staff in general?
8. What evidence can you give me of nurses working at a higher level?
9. Has the number of nurse-led clinics increased? Give number.
10. Have the nurses increased the independent work they are doing? Give examples.
11. Can you quantify any changes in the level of paper work doctors (and nurses) have to do? Has there been any changes to the preventive work nurses are able to do? Examples?
12. What effects (if any) have there been on doctors’ workload (size)?
13. What effects (if any) have there been on the doctors range of tasks (expanded practice)?
14. Are there any other changes that have been made as a result of having a PCPA?
15. Do you think there is a business case for having a PCPA?
16. Would you employ another PCPA in training?
17. Would you be prepared to pay course fees for one of your staff to train as a PCPA?

Identifying numbers for the practice managers do not correspond with the identifying numbers for the doctors to avoid identification of any individual practice.
18. Would you employ another qualified PCPA?
19. What do you see as the future of the scheme?
20. Overall what is your perception of the role of the PCPA?
   - High enthusiasm.
   - Moderate enthusiasm.
   - Conditional enthusiasm.
   - Not enthusiastic.

Appendix 13: Direction and delegation guidelines

Notes from the Nursing Council guidelines

These guidelines which include principles for when direction and delegation can occur provide the necessary protection to ensure that health consumers’ needs are met by the appropriate healthcare professional/personnel. Also, the RN, the practice staff and the person being delegated to, have responsibilities in regard to giving/receiving direction and delegation.

Principles of direction and delegation

When delegating the RN must take into account:

- The health status of the health consumer.
- The complexity of the delegated activity/nursing intervention.
- The context of the care.
- The level of knowledge, skill and experience of the person to perform the activity.

AND

The decision to delegate **MUST be consistent with service provider policy.**

The RN **MUST** ensure that the person carrying out the delegated activity:

- Understands the delegated activity.
- Has received clear appropriate direction.
- Knows who and under what circumstances they should ask for assistance and who and when to report to.

**Responsibilities of person carrying out the delegated activities**

- Accepting and recognising legal limitations and ethical parameters of the role.
- Accountable for own actions and understand own scope.
- Know who RN is providing direction.
- The person should inform the RN and seek guidance (if appropriate) if the delegated task appears more complex or if they are uncertain of the requirements or the client’s response at any stage of the activity.
- The person must not accept any direction or delegation they feel is beyond their capabilities or they have not been trained to perform an activity.
- Inform RN of any changes in condition of health consumer.

**Responsibilities of employer**

- Appropriate skills mix.
- Employ suitable staff to perform various roles and to provide adequate training for the provision of safe and competent care.
- Ensuring RNs are supported and are competent to safely delegate.
- Clear role descriptions based on scope, direction and delegation policies and communication systems to support RN in their role.
- Process for monitoring standard of care and documentation/reporting procedures re client related concerns.
- Ensuring that unregulated HCWs understand their delegated activities and responsibilities.
- Non-nurse employers are expected to seek professional advice on staffing, skills mix and delegation of nursing activities.
Developing policies, job descriptions and MOU that clarify the relationship between RNs and unregulated workers in community settings particularly when they are employed in different settings.

Supplied by Kath Seton, Department of Nursing, Faculty of Social and Health Services, Unitec. The full Guidelines for Direction and Delegation can be found on [www.nursingcouncil.org.nz/Publications](http://www.nursingcouncil.org.nz/Publications)

Appendix 14: Required skills list for PCPAs

(Plus other skills listed by some during the course - see PCPA Course, page 9.)

**Skills check HCW Course**

- Introduces self clearly to patient.
- Demonstrates getting patient consent.
- Infection control.
- Demonstrates medical asepsis- hand washing.
- Practices standard precautions. PPE: gloves, masks, gowns as appropriate.
- Awareness of sharps protocol.
- Properly disposes of biohazardous materials.
- Perform alcohol-based hand sanitisation.
- Apply and remove clean disposable (non-sterile) gloves.
- Sanitise instruments.
- Perform chemical sterilisation.
- Wrap instruments for the autoclave.
- Sterilize instruments in the autoclave.

**Clinical skills**

- Prepares the examination room; privacy, equipment, supplies, examination table.
- Assists with patient; physical examination, chaperoning.
- Measure and record weight of an adult, child and infant.
- Calculate and record a BMI.
- Measure and record body temperature; tympanic, digital thermometer.
- Measure and record radial pulse-rate, rhythm, volume.
- Measure and record respiratory rate.
- Measure and record blood pressure; standing and sitting.
- Specimen collection; urine, stool, sputum.
- Instruct a patient in collection of a MSU.
- Urinalysis using a reagent strip.

**Front desk**

- Demonstrates how to use a multiline telephone system.
- Effective equipment operation of a; photocopier, fax, scanner, calculator, computer.
- Demonstrates call management: identifies office, self caller, screening, confidentiality, gathering data, taking messages.
- Manages problem calls; unidentified caller, angry patient, family member.
- Manages emergency calls.
- Schedule and manage appointments.
- Rescheduling and cancellations.
- Schedule a new patient/new patient enrolment.
- Registering an ACC patient M45.
- Demonstrate understanding of fee structure in practice.
- Taking a payment: invoices, EFTPOS, receipts.
- Payment codes.
- Petty cash.
Safe manual handling

- Assisted to stand.
- Assisted stand to sit.
- Wheelchair/chair to examination table.
- Examination table to wheelchair/chair.
- Assisted car to wheelchair.
- Assisted wheelchair to car.
- Other.
- Apply ice pack.
- Apply tubular bandage.
- Order and maintain health information pamphlets.
- Incident forms completed as per practice policy.
- Patient dashboards completed as practice policy.
- Patient clinical notes completed as practice policy.
- Restocks as per practice instructions.

Additional skills added by individual practices at the end of 2012 as PCPAs reached completion

- Recalls.
- Wound care.
- B4 school.
- Setting up for minor operations.
- Assisting at minor operations.
- Chaperoning if RN not available.
- PCPAs role in an emergency.
- Venepuncture.
- Audits.
- Rosters.
- Banking.
- Claims for ACC, immunisations, GMS, query builders.
- Restocking rooms.
- Ordering supplies.
- Removal of sutures and staples.
- Dressings and wound management.
- Liquid nitrogen stock management.
- Names of patients and consult expectations.
- Charting new medications following GP visit to nursing home.
- Assessing what items are required for GP to take to rest home i.e. liquid nitrogen.
- Ensuring that pharmacy receives CD prescription for patient in nursing home in advance of blister pack preparation.
- Faxing prescriptions to pharmacy.
- Phone calls to patients with INR results and instructions for warfarin, as per GP direction.
- Managing faxed cremation certificates.
- Follow up letter/information to patient about test results under direction and delegation of RN.
- Texts to remind patients re smoking cessation,
- Meet and greet patients,
- Inform patients if GP is running late.
- Calls to hospitals to follow up patient appointments and results.
- Phone calls to lab for results.
- Phone call to radiology for results.
- Phone calls to ACC for ACC numbers.
- Setting up and assisting GP with ear suction.
- Setting up and assisting GP/RN with punch biopsy.
- Recording phone consultations in patient notes when phoned with information or instructions from GP or RN.
• Recording information in notes if text has been sent.

Skills Checklist Part A and Part B PCPA Course

• These are activities students are educated to perform. Competency in these skills **MUST** be achieved unless the Clinical Teacher/Practice Nurse Manager indicates that this is not appropriate in your workplace.
• In completing these skills the PCPA works/practices under the direction and delegation of a Registered Nurse (RN)/General Practitioner (GP) or Practice Manager (PM).
• Your competence is be signed off by:
  • Yourself
  • **AND** the registered nurse/GP/PM.
• In the performance of skills, you are expected to work under direction and delegation as determined for the PCPA role (refer Graduate profile).
• When assisting with care, consider the following principles in every circumstance:
  • Safety.
  • Client comfort and wellbeing.
  • Privacy and dignity.
  • Asepsis.
• This skills checklist **MUST** be completely signed off by **4th June 2013** (unless Clinical Teacher/Practice Nurse Manager indicates not applicable in your placement).

<table>
<thead>
<tr>
<th>Practical/Clinical skills Part A  PCPA Course 2012</th>
<th>C/NC</th>
<th>Date</th>
<th>Own signature</th>
<th>RN Signature</th>
<th>Comment</th>
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<tbody>
<tr>
<td>Oxygen Saturation</td>
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<td>Apex Beat</td>
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<td>Removal of Luer</td>
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<td>Cold chain and storage of vaccines</td>
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<td>Peak Flow Test</td>
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<td>Spirometry- as appropriate</td>
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<td>Inhaler Technique – use of spacer</td>
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<td>Visual Acuity- Snellen Eye Chart</td>
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<td>Ishihara colour vision Test</td>
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<td>ECG Recording</td>
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<td>HCG test</td>
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<tr>
<td>Setting up and assisting with smear taking/IUD4</td>
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<td>CBG (Capillary blood glucose test)</td>
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<td>Patient Dashboard</td>
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### Clinical skills Part B

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<td>Surgical asepsis hand wash</td>
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<td>Setting up a sterile field</td>
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<td>Assisting with minor surgery</td>
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<td>Wound dressing (basic)</td>
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<td>Removal of sutures*</td>
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<td>Removal of steristrips</td>
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<td>Safe storage of oxygen</td>
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<td>Other (* unless Clinical Teacher/Practice Nurse Manager indicates not applicable in your placement)</td>
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### Administrative tasks and other skills

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<th>Self Sign (initials)</th>
<th>RN sign</th>
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<tbody>
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<td>Recalls/Reminders</td>
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<td>Cx Smear</td>
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<td>Mammogram</td>
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<td>Immunisation</td>
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<td>Other</td>
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<td>Equipment maintenance as appropriate to practice e.g. sphygo; scales</td>
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<td>Claims reconciliation (this section is only signed off where this is part of your Job Description Maternity)</td>
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<td>Immunisation</td>
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<td>ACC</td>
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<td>GMS</td>
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<td>PHO</td>
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C = Competent   NC = Not yet competent