New graduate nurses as knowledge brokers in general practice in New Zealand: a constructivist grounded theory

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Abstract

Practice nursing in New Zealand is not well described in the literature. One survey illustrated that most of the New Zealand practice nurses sampled did not know of the country’s two premier evidence-based health websites. A recent review compared general practice in the UK, New Zealand and Australia and found that whereas there had been significant developments in empowering the practice nurse workforce to run nurse-led clinics in the UK, New Zealand and Australia lagged behind. The aim of this reported constructivist grounded theory study was to investigate practice nurses’ use of information. Conducted in Auckland, New Zealand, data were collected through ethnographic techniques in one general practice between September 2009 and January 2010 to enhance theoretical sensitivity to the area of information use. Subsequently, six experienced practice nurses (one twice after moving jobs) and five new graduate nurses from five different general practices were interviewed, using open-ended questions, between January 2010 and August 2011. Concurrent data collection and analysis occurred throughout the study period. The use of memos, the constant comparative method, data categorisation and finally, data abstraction resulted in the final theory of reciprocal role modelling. Experienced practice nurses role modelled clinical skills to new graduate nurses. Unexpectedly, new graduate nurses were unconscious experts at sourcing information and role modelled this skill to experienced practice nurses. Once this attribute was acknowledged by the experienced practice nurse, mutual learning occurred that enabled both groups of nurses to become better practitioners. Graduate nurses of the millennial generation were identified as a resource for experienced practice nurses who belong to the baby boomer generation and generation X.

Keywords: constructivist grounded theory, general practice, graduate nurses, New Zealand, practice nurses

Introduction

Practice nursing in New Zealand is not well described in the literature. A recent systematic review illustrated that practice nurses in both New Zealand and Australia did not provide nurse-led services in general practice to the same extent as their peers in the UK (Hoare et al. 2011). In addition, an earlier study revealed that the two freely available New Zealand evidence-based health websites were rarely used by practice nurses (Hoare et al. 2008b). New Zealand practice nurses are usually employed by general practitioners who operate within a small business environment. Authors have criticised this arrangement, arguing that the role of the practice nurse is contingent on the needs of the employer, rather than the enactment of New Zealand’s Primary Health Care Strategy (King 2001, Docherty et al. 2008). In addition the role has been slow in developing since the introduction of practice nurses into general practice in 1970.
(Docherty 1996). At the time payments were made to support general practitioners (GP) to provide them with assistance to focus on tasks only a doctor could perform. These payments known as the Practice Nurse Subsidy Scheme (PNSS) were never attached to nursing duties and, as a result, nurses were employed to provide reception and cleaning services alongside nursing care. The situation is much the same 40 years later, with a study conducted in 2008 illustrating that 75% of practice nurses provide reception and cleaning duties (Morris 2008). Furthermore, a survey of 384 New Zealand practice nurses in 2006 found that 29.8% were aged 50–60 years old with only 3.6% aged 20–30 years (Finlayson et al. 2009). Although globally the nursing workforce is ageing (Stuenkel & Cohen 2005, Wilson et al. 2008), New Zealand has the added problem of a nursing workforce peaking in older age bands when compared with the UK (North 2011). Unlike the UK, where the primary health care reforms of the 1990s included the implementation of plans to expand the role of primary health care nurses (Hoare et al. 2011), there has been no development at a national level in New Zealand to address optimising the primary health care nursing workforce (Finlayson et al. 2009). Due to funding arrangements and no strategic direction, practice nurses, who form part of this group, have little scope to advance their roles (Hoare et al. 2008a, 2011).

In summary, practice nurses in New Zealand are members of an ageing workforce, who undertake reception and cleaning services in addition to providing nursing care, with many unaware of evidence-based freely available resources.

In 2008, the Government’s expanded New Entrant to Practice Programme (NETP) (Counties Manukau District Health Board 2010) placed a number of new graduate nurses in general practices to provide an opportunity for them to experience this environment without having to work in a hospital first. District Health Boards (DHB) contribute to the graduate nurse’s salary and the general practice provide a practice nurse willing to undertake a 2-day course before preceptoring the new graduate nurse (Haggerty et al. 2009). This initiative, which has continued annually, was to have unexpected effects and resulted in the substantive theory of reciprocal role modelling. The findings from this constructivist grounded theory are the focus of this article.

Background

Internationally, difficulty with getting evidence into practice has been a long-standing topic of debate, with many authors discussing the tardy transit of evidence into practice (Estabrooks et al. 2003, Rycroft-Malone et al. 2004, Mantzoukas, 2007, Gerrish et al. 2011, Mills et al. 2009, Squires et al. 2011). Until recently, implementing evidence-based practice was regarded as the individual practitioner’s responsibility (Rycroft-Malone 2008). Passive diffusion of knowledge from research into practice is a rare occurrence (Lomas, 1991). Kitson et al.’s (1998) seminal work illustrates three core elements to getting research into practice: the level and nature of the evidence; the context into which the research should be placed and the way the process is facilitated. Those three elements have equal standing, with active facilitation recognised as likely to lead to uptake of evidence (Kitson et al. 1998, Harvey, et al., 2002). Systematic reviews have concluded that individual nurse characteristics have no bearing on research use (Squires et al. 2011). Change agents and knowledge brokers, however, do impact research use and their roles appear in many guises with different labels (Rycroft-Malone et al. 2004, Thompson et al. 2006). The role of new graduate nurses in acting as knowledge brokers is a novel concept. These nurses act as linking agents; the term was first described by Havelock, Guskin, Frohman, Havelock and Huber (1971). The idea of ‘linkers’ is that they represent the human interface connecting new information to practitioners. The reasoning for the nomenclature of linking agents is that they bridge the gap between innovators and practitioners who work in incompatible worlds. Linking agents can be found at any level of an organisation (Thompson et al. 2006). The findings from this study have international relevance.

Methods

As little was known of the topic of information use by practice nurses in New Zealand, a constructivist grounded theory design was the methodology of choice by the authors for this study. Constructivist grounded theory is first described by Charmaz a student of Glaser and Strauss’ the originators of grounded theory methods (Charmaz 2006). Charmaz (2008) scholarship has moved grounded theory into the social constructionist paradigm where the research process emerges from interaction between the investigator and participant and takes into account both of their positions. Commencing September 2009 for 2 years, the first author aligned with the principles of constructionism in a process of data collection and analysis to construct a grounded theory that accounts for the topic of inquiry.

Participants and recruitment methods

The first author’s (KH) general practice workplace was the site of the initial ethnographic fieldwork, a
method consistent with grounded theory design. This ethnographic phase raised the author’s theoretical sensitivity to the research phenomenon (Hoare et al. 2012a,c). Situated in South Auckland, the general practice was, at the commencement of the study, owned by four general practitioners (GP) who employed a part-time nurse practitioner (KH), two practice nurses and one new graduate nurse. Following the ethnographic phase of the study KH became a business partner with the GPs. The process of gaining consent from team members at this general practice to participate in the study was as follows: KH explained the study at a practice clinical meeting and then left the premises for the team to discuss the research and their prospective participation. Only members of the team who agreed to partake in the research, by signing a consent form, were included in the ethnographic phase. Subsequently, practice nurses from the Auckland region of New Zealand were invited to take part in the study. An email invitation and participant information sheet were sent out to practice nurse networks via the Primary Health Organisations (PHO). Consistent with the method of theoretical sampling, participants who demonstrated characteristics congruent with developing categories were invited to participate in a face-to-face interview conducted at the practice nurse’s workplace. There was no predetermined number of participants. Cessation of data collection occurred when categories were saturated.

Data collection

During the ethnographic phase of data collection four focussed codes were constructed from numerous initial codes. These focussed codes were then explored with the first participant from an alternate general practice in a face-to-face interview. Theoretical sampling is a method of identifying participants with whom data will be generated to further develop focussed codes and initial categories, and was used to select the further 10 practice nurses who participated in the study (one was interviewed twice). Each practice nurse interviewed chose a time and location that was convenient for them which was generally their workplace. Participants signed a consent form prior to a face-to-face interview which was audio-recorded and subsequently transcribed by KH.

Ethics approval

This study was approved by Monash University Standing Committee on Ethics in Research.

Acquiring theoretical sensitivity through the use of ethnographic techniques

The concept of theoretical sensitivity is unique to grounded theory research and was first described as a person’s deeply personal reflection of themselves, their area of inquiry and their intellectual knowledge gained through reading and used in everyday thought (Glaser & Strauss 1967). Birks and Mills define theoretical sensitivity as ‘the ability to recognise and extract from the data elements that have relevance for your emerging theory’ (2011, p. 176). As a nurse practitioner, KH was very familiar with a general practice environment and so already had begun acquiring theoretical sensitivity to the substantive area of inquiry. The code and ensuing category of role models was born from her experience of observing a colleague who freely and regularly shared information with the rest of the team. By the end of November 2009 KH perceived she had developed sufficient theoretical sensitivity to explore information use with the first participant in a formal interview, selected because they were the first to volunteer.

Examples of theoretical sampling

The memo written following this first interview highlights KH’s perceived importance at that time of role models and relationships in relation to practice nurses using information in their work:

Reflections straight after interview 26th November 2009

The importance of relationships hit me in the face. Post graduate study really important. Good relationship with the GP. Trip to England. Having role models. I guess from this interview I will pursue this whole idea of role models and who they are. That there’s no career pathways [in New Zealand].

Following this interview KH further theorised that new graduate nurses would need role models and so undertook the second interview with a graduate nurse (GN1), working at KH’s general practice. An incident of communication breakdown between the graduate nurse and a doctor related during this interview caused great hilarity:

GN1: I felt reasonably confident in what I wanted to do and then he [doctor] started talking about petroleum and I couldn’t understand why on earth he would want me to put like ... there was a tub of Vaseline ... and I just could not grasp why he would want me to put like all this Vaseline over someone’s wound and I was thinking God this is weird but he obviously ... you know ... knows what he’s talking about and so I went and got the tub and I showed it to him and he looked at me like … well this is strange,

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but all he meant was that those dressings [that] used to be called petroleum impregnated gauze or something obscure like that ... so we were just talking a different kinda language whereas we (both of us laughing in the interview) both wanted exactly the same thing ... the poor man lying on the table’s like ...... laughing lots.

The interview with the graduate nurse had been fun, an observation that was repeated when other new graduates were interviewed, but importantly a significant initial code ‘talking the language of evidence’ was also identified from this interview. GN1 recruited her friend, who was employed by a PHO and who spent time working in a number of general practices, to be the next participant so that KH could further explore the experiences of graduate nurses using information in general practice as there was a sense that ‘talking the language of evidence’ might be a specific characteristic of this generation of nurses.

Coding data

Charmaz (2006) uses the terms initial coding and focused coding to analyse data. Initial coding occurs line by line and is the step between collecting data and theory speculation. Glaser (1978) emphasises the importance of paying close attention to coding. KH coded data using the QSR NVivo 8 (QSR International Pty Ltd., Doncaster, Victoria, Australia) software package, where she placed initial codes into free nodes and focused codes into tree nodes. Charmaz’s influence resulted in many of the codes becoming gerunds (verbs acting as nouns) that denote action, for example ‘being a leader’, ‘being new’, ‘talking the language of evidence’. Some focused codes eventually became categories or subcategories. KH and JM analysed the initial categorisation schema and recategorised some data changing codes to fit the new categories after constantly comparing the codes and the data they represented. At this stage, codes and their categories were printed and spread over a three metre table to allow KH and JM to sift, sort and finalise the categories. From these evolved categories it was possible to write the storyline (Strauss & Corbin 1990, Birks & Mills 2011) of what was happening in the data.

Rigour and trustworthiness

Field notes, dated memos, transcribed interview notes and notes from meetings with the research team provide an audit trail of KH’s evolved grounded theory. In addition, the manuscript Dancing with data: Acquiring theoretical sensitivity in a grounded theory study (Hoare et al. 2012c) was written and accepted for publication, which explicates in full the process of grounded theory data collection and iterative sampling used in this study.

Data analysis

Saturation of categories was reached following 12 interviews with 11 practice nurses, five of whom were new graduates, all of them millennial generation (born between 1981 and 2000) (Strauss & Howe 1991). The remaining six practice nurses were regarded as experienced, having worked in general practice for more than 3 years. These nurses belonged to the generation X (1961–1980) or baby boomer (1945–1960) generation (Strauss & Howe 1991).

Analysis of the findings is presented using storyline, a grounded theory method developed by Strauss & Corbin (1990) and later advanced by Birks et al. (2009) and Birks & Mills (2011). Reciprocal role modelling was identified as the core category, and is represented as a grounded theory model in Figure 1. Reciprocal role modelling has three categories, becoming willing, realising potential and becoming a better practitioner. The first of these, becoming willing is not evidenced in this report due to word constraints and is published elsewhere (Hoare et al., 2012b). However, a synopsis of the category becoming willing is provided to allow the reader to link the three categories together in a meaningful way. The evidenced story for this article commences with the second category of realising potential followed by the third category of becoming a better practitioner. Data fragments pepper the script to evidence and illustrate how this theorisation is truly grounded in the data.

Results

Becoming willing

Over time, during which a respectful relationship is built, the new graduate nurse (GN) and experienced practice nurse (EPN) are becoming willing to prove themselves to each other in their respective roles. The GN is cognisant of the EPN’s clinical skills who proves herself by teaching these skills to the GN as well as being a source of knowledge about the local community. Meanwhile the GN is developing confidence within the safety of a supportive multidisciplinary learning environment and begins to display knowledge of current thinking around clinical topics, sources of evidence and computer skills to the EPN. In this way the GN is proving their usefulness to the EPN. In the final stage of this category the GN begins to make discerning decisions about who they seek information from within the wider general practice...
team. Although the EPN is still their main source of information, they start to identify other team members who are helpful to seek information from. The subcategory of becoming willing, discerning decision-making, is axial to the second category realising potential.

Realising potential

Three subcategories comprise the category realising potential; recognising strengths, deploying unconscious expertise and discovering the nexus. Axial coding forms the juncture between categories and links relationships between categories at a conceptual level (Corbin & Strauss 2008). Thus, the following data fragments illustrate how discerning decision-making, a subcategory of becoming willing, links to the subcategory of realising potential called recognising strengths.

Recognising strengths

As the relationship evolves, the GN recognises the strengths of the EPN(s) she works with:

GN1: With name (EPN), she’s very knowledgeable (about chronic care) and it kinda makes me want to be as good.

The EPN is the GN’s source of expertise about clinical nursing skills in preference to others, as the GN sees them as the key person to ask questions of. Educators employed by the Primary Health Organisation (PHO) do not have as much credibility with the GN as the EPN mentor, even if they are providing the GN with useful sources of information:

GN3: There’s one lady who comes out from (the PHO) to see me every now and then just to see how I’m getting on and so she’s been really good …… She’s given me like bits and pieces of things where I can go to and websites something like that if I need any information but erm in regards to sort of clinical information it’s more the other nurses I go to for clinical information.

The most important source of information for the GN is their EPN mentor. Qualities other than the EPN’s clinical skills, such as communication skills are also recognised. The EPN is valued by the GN who sees them operating with other team members. By valuing the role, the EPN plays within the general practice team, the respect of the GN towards the EPN is enhanced:

GN5: I really respect (EPN) for her experience like she’s excellent in that and like the admin staff can give her things and she’s never gonna turn them away and I think that’s quite admirable in a busy practice nurse.

This respectful relationship results in the GN positively viewing how and where EPNs have gained
their knowledge and experience from, cognisant of the value of clinical practice in different workplace environments.

However, GNs are more aware of current modes of accessing evidence-based information than EPNs. When asked where they would source information from about wounds one participant gave the following answer:

GN1: If it was a new product umm I might do some research of my own just to have a look cause if I'm not sure ...... I could go and look at the trial or find information like that whereas I think a lot of their (EPNs) information comes from practice, you know practising a long time and sort of experiential rather than say doing a literature review of different dressings.

Recognising the strengths of the EPN mentor results in a positive cycle of affirmation. The more acknowledgment the GN gives to the EPN with regard to their clinical skills, the better disposed towards the GN the EPN will be. The GN will grow in confidence within this positive relationship until they reach the stage of deploying unconscious expertise in sourcing information and sharing this with the EPN.

**Deploying unconscious expertise**

Discerning decision-making develops to the point where the GN may access information to refute or support the information she has received about a specific condition or particular skill from the EPN and maybe another member of the team. The GN feels confident enough to assess a range of options to source information from; they are deploying their unconscious expertise:

GN1: I might Google it, do a quick review on the internet, or go and ask one of the other nurses or if I think it's something that a doctor needs to look at then I'll go and ask one of the doctors to come in and have a look and just get their opinion and if I sort of don't get something I agree with I might ask someone else.

In addition, they demonstrate unconscious expertise in the language of evidence they use:

GN3: My research teacher would kill me if I said this but usually Google. Google is actually a really good starting point I find for information (laughing) .... and I know what to look for because I know what sort of research to look for and what's will be good research and what is not so I know to avoid the ones that say this and this but then have nothing to back it up kinda thing so I guess in that aspect I'm ... a lot more aware of what I'm looking for, and I know where to go if I need really good evidence as well.

The content of their language is profoundly embedded with references to evidence-based resources when asked where they would access information from:

GN3: Usually I would go to either Cochrane or Pubmed if I had access to it.

GNs are so adept at scanning reports and synthesising research materials that they know what to look for in the literature and perceive that not all clinicians would find information as easy to access as they do. When asked about synthesising literature pertaining to evidence-based practice:

GN5: Often you would pull up something that would be 300 pages and there would be no executive summary at all so from a clinician's perspective it's relatively hard to find the information that you need.

As KH listened to the tapes from the graduate nurses as she was transcribing, she wrote the following memos:

**Memo. May 5th 2011**

Looking at the data I can see the value of new graduate nurses in primary health care and the way they may lift the game of the practice nurses, because they (GNs) are technically savvy and they know where to look for information.

**Memo. August 15th 2011**

The new grad nurses are unconscious of their knowledge about evidence-based information. It is part of them, the way they are, the way they have been taught. They probably think that everybody knows what they do about databases and guidelines.

The GNs show the EPNs websites, computer programs and are able to manipulate technology confidently and competently. The EPN realises that the GN can tap into sources of information they never knew existed. Meanwhile, the GN, whose very way of being incorporates all aspects of modern technology and social networking by facebooking, texting and tweeting, has no idea that the EPN may be realising that they (the GN) have strengths that will enhance their practice. The GN is an unconscious expert in finding information. They do not recognise this as a skill. To the GN being able to use technology is as natural as breathing. By deploying their unconscious expertise to the EPN they are realising their potential.

**Discovering the nexus**

The next subcategory of discovering the nexus occurs at the interface of GN and EPN’s expertise. The GN demonstrates to the EPN that their abilities to source information are such that the EPN can learn from them. The GN aspires to become as competent as the EPN in clinical skill acquisition and so the EPN is
already a role model for the GN. There is a light bulb moment when the EPN realises that the GN’s skills are well developed in information sourcing and therefore an element in keeping up to date with best practice and computer use. In addition, GNs with their recent varied clinical experience during their undergraduate degree can prove helpful in clinical situations as was the case in the following example:

GN4: It wasn’t an emergency emergency but erm we got into the treatment room, one of the nurses was trying to do something but she wasn’t doing it right, it was trying to put an IV in. The doctor was doing it but she kept getting the wrong thing, she didn’t know what to get so I just pointed out to her that that’s not the right thing (tape fades) she’s a good nurse, she’s really lovely and she took it quite good.

KH so was she quite grateful?

GN4: Oh yes she was she was like ‘Oh thanks I didn’t know that’ (laughing).

As the EPN begins to recognise the GN as an unconscious expert in sourcing information, the GN’s status changes and they can be perceived to be as useful as the doctors in providing information illustrated by the following example:

EPN7: If a doctor is free I’ll ask a doctor, if (name of GN) is free I’ll ask her because to me the new grad nurses, I think they’re smarter than us looking out for information.

Once the EPN has reached this stage where they feel they can ask the GN for help in sourcing information, reciprocal role modelling has occurred. With both sets of practitioners learning from each other and sharing information, the final category of becoming a better practitioner is established.

**Becoming a better practitioner**

The final category in the theory of reciprocal role modelling has two subcategories, routinising ways of thinking and learning ways of making information useful for the team.

The code becoming a better practitioner initially arose from an interview with an EPN who stated:

EPN5: She’s [GN] a bit more internet savvy than I’ve been and I wasn’t using the MIMS from Medtech (practice management system)….. I’ve got a bit behind on (medications) what some of them are actually for ….. Having her there has actually allowed me to become a better practitioner.

Charmaz (2006) classes this type of code become a better practitioner as an in-vivo code, and states that although these codes may be ‘catchy’ (2006), they do not always stand on their own in a robust grounded theory. The category of becoming a better practitioner, however, as well as being a catchy in-vivo code, is integrated into the grounded theory of reciprocal role modelling and illustrates the eventual outcome of this process.

**Routinising ways of thinking**

The GN has been a major influence on the EPN to the point where she has started to think differently about accessing and using information. The EPN now routinely uses the computer to access information and to prepare presentations for information sharing:

EPN6: I never had any problems asking (name) GN or (name (GN) to show me things because I never had any computer training.

As well, the EPN now thinks differently about ways she can access continuing professional development. No longer do they slavishly attend education sessions which may have no relevant content, they become discerning about their learning needs. The EPN is starting to think ‘outside the box’ and theorise about different ways to sort and access information, becoming a critical thinker and reflecting on her practice:

EPN5: Cause when you’re working down at the coal face you tend to just get stuck in and don’t have time to update yourself necessarily and it’s only what you’ve been told that you take on board whereas by having new graduates it makes you really look at your own practice and why you do things.

The GNs introduce the EPNs to new ideas. Within the boundaries of a respectful relationship, the EPNs accept the GNs knowledge and although it may be challenging for the EPN, they are willing to consider new information:

EPN2: Yeah a lot of these new graduate nurses have come out with a lot of knowledge and new information and what’s best practice at the moment and can be quite challenging, a lot of the nurses here have got new ideas and different ways of thinking. We’ve found them (GNs) really good because again it just makes us think about our own practice.

Having the GN introduce them to new ways of accessing information and online learning cause EPNs to reconsider their traditional mode of continuing professional development:

EPN3: So the realisation. I’m thinking my information (needs) [are] now outside of cell groups’ (formal education sessions provided by the PHO).

The GN also realises that she may have a role in the team in making information more accessible or help others to try new ideas which leads to the final sub-category.
Learning ways of making information useful for the team

This final subcategory in the process of reciprocal role modelling occurs when the GN on realising that she knows how to access information, starts to think about how she can help the other team members apply her knowledge into clinical practice:

GN5: She (doctor) was doing some research with a professor out at (place) about janola baths and eczema because she said the evidence on janola baths is relatively weak and so I said well I’m doing an eczema clinic so we might be able to talk to (name of EPN) about how we look at janola baths.

The GN above exhibits reasoned thought and her knowledge about strengths of evidence, thinking of ways to test a treatment within a service she provides. The following data segment refers to a GN problem-solving how she could help her EPN mentor source new information:

GN1: I think it would have to be very like safe for (name of EPN), like I think if she had email updates of little two minute segments of information that she could then follow up [if] it felt relevant to her, whereas if you just gave her loads of access to articles she wouldn’t have a bar of it or she’d just be ... nah I’m too busy.

The GN has learnt from her role model the EPN how to communicate effectively; she still confers with the EPN about how she should disseminate her information. The EPN acknowledges the GNs expertise in sourcing information. Both sets of nurses are becoming better practitioners and have reached the final stage of Reciprocal Role Modelling.

Discussion

Translating research and implementing it in practice is a first step to improving patient health outcomes. The requirement for health practitioners to achieve this goal is the fundamental premise of clinical governance (Scally & Donaldson 1998). Access to information for all health practitioners, including nurses is therefore a priority. Research in Australia and New Zealand has illustrated the low skill level of practice nurses in managing knowledge translation (Hoare et al. 2008b, Mills et al. 2011) or the application of research evidence to practice. Until recently, the process of getting evidence into practice was the individual practitioner’s responsibility (Rycroft-Malone 2008). Although even last Century Kitson et al.’s (1998) seminal work on getting evidence into practice recognised facilitation of evidence into practice as one of the three core elements which was of equal importance to, the level of evidence and the context of implementation. Increasingly the value of knowledge brokers is being recognised (Thompson et al. 2006, Gerrish et al. 2011, Squires et al. 2011). This term is defined as ‘the human force that makes knowledge transfer (the movement of knowledge from one group of people to another) more effective’ (Canadian Health Services Research Foundation 2003, p. i). In our study, GNs acted as knowledge brokers for EPNs. This encouraging finding points to the critical role of the millennial generation in facilitating evidence-based resource use in general practice. The millennials have been described as the newest generation to enter the workforce and are collaborative, optimistic, technology dependent and used to multitasking (Dols et al. 2010). Our findings suggest they become role models to EPNs in accessing and using information. Although the study is limited by its geography, the findings are worthy of further investigation internationally.

Conclusion

An ageing workforce without the requisite skills to implement evidence into practice will not address the aim of New Zealand’s Primary Health Care Strategy to reduce inequalities in health between ethnic groups (King 2001). Whereas getting evidence into practice has been fraught with difficulties internationally (Estabrooks et al. 2003, Rycroft-Malone et al. 2004, Milner et al. 2006), attracting millennial generation nurses into general practice may be a solution to getting evidence into practice by role modelling this skill to other team members. In our study, GNs’ seemingly innate ability to talk the language of evidence and manipulate technology, resulted in unconscious knowledge brokering.

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