Canadian Nurse Practitioner Initiative

Initiative canadienne sur les infirmières et infirmiers praticiens

PRACTICE FRAMEWORK

for

NURSE PRACTITIONERS IN CANADA

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CANADIAN NURSES ASSOCIATION
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Table of Contents

1. INTRODUCTION 1
2. CONCEPTUAL OVERVIEW: THE NP PRACTICE CONCEPTUAL MODEL 2
   2.1. The Discipline 3
      2.1.1. Advanced Practice Nursing 4
      2.1.2. Definition and Scope of Practice 5
      2.1.3. Title and Licensure 6
      2.1.4. Examination 7
      2.1.5. Legislation and Regulation 7
      2.1.6. Liability 8
   2.2. The Patient 8
      2.2.1. Individual, Family and Community 9
      2.2.2. Information and Health Issues 9
      2.2.3. Quality and Patient Safety 10
   2.3. Context 10
      2.3.1. Practice Pattern Arrangements 10
      2.3.2. Public and Professional Understanding 11
      2.3.3. Workplace Organization and Management 12
      2.3.4. Collaboration and Consultation 13
      2.3.5. Funding and Remuneration 13
   2.4. Nurse Practitioner 14
      2.4.1. Knowledge and Skills 15
      2.4.2. Education and Continuing Development 16
      2.4.3. Experience 16
      2.4.4. Patient Populations and Issues of Interest 17
      2.4.5. Values, Attitudes and Capacities 17
      2.4.6. Interprofessional Practice 17
      2.4.7. Evidence-Based Practice 17
      2.4.8. Health-Care System 18
3. RELATED RECOMMENDED ACTION STATEMENTS 19
4. CONCLUSION 20
5. REFERENCES 21

APPENDICES
   Appendix A: A Conceptual Model for Nurse Practitioners
   Appendix B: Practice Component Literature Review Report
   Appendix C: Nurse Practitioner Professional Practice and Liability Issues
   Appendix D: Nurse Practitioners in Canada: A Single Stream Approach
   Appendix E: Practice Component Literature Review Report - Supports, Barriers, and Implements to Practice

Table of Figures

Figure 1: NP Practice Conceptual Model 3
Figure 2: Discipline Element of the NP Practice Conceptual Model 4
Figure 3: Competencies of ANP Related to NP and CNS Roles 5
Figure 4: Patient Element of the NP Practice Conceptual Model...................................... 8
Figure 5: Context Element of the NP Practice Conceptual Model 10
Figure 6: Nurse Practitioner Element of the NP Practice Conceptual Model.................. 15

1. INTRODUCTION

Variation in title, role, educational preparation, scope of practice and reliance on medical directives or other legislation and regulation, public and other provider understanding of the nurse practitioner (NP) role all pose barriers to the sustained implementation of NPs. A pan-Canadian approach to understanding NP practice offers a thoughtful planning framework for positive and sustained outcomes.

As such, the *Practice Framework for Nurse Practitioners in Canada* (NP Practice Framework) is intended to support full and effective integration of NPs. It has at its core a commitment to a basic underlying conceptual model. This model is comprised of components, including the NP, context, client and discipline. It also includes five specific, related recommended action statements for definition, title and role, licensure[1], liability, as well as issues including collaboration, which need to be considered to sustain the NP role.

This document is the product of an extensive research and consultation process which included a comprehensive review of literature pertaining to NP education, along with interviews and round table consultations with key informants and stakeholders from across Canada.

The *Practice Framework for Nurse Practitioners in Canada* is one of five strategic pillars which together comprise a broader Canadian NP framework. In this context, the NP Practice Framework cannot stand alone. Rather, its effectiveness depends on the combined strength of all five pillars and on how well each supports the other in achieving the overarching goal to develop a pan-Canadian framework to promote the sustained integration of the role of the NP in primary health care across Canada.

[1] For the purposes of the NP Practice Framework the term licensure is used to mean either licensure or registration.

2. CONCEPTUAL OVERVIEW: THE NP PRACTICE CONCEPTUAL MODEL

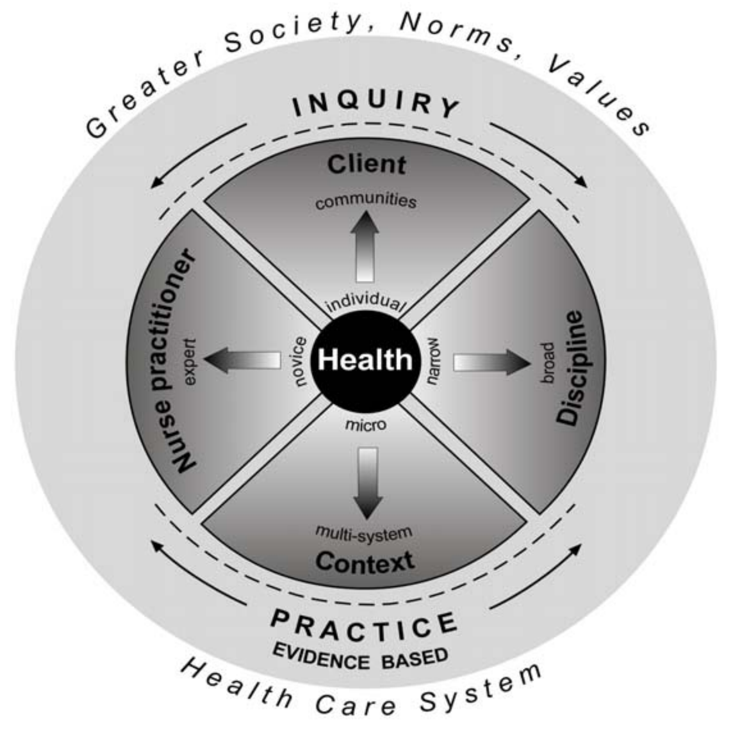
To facilitate the identification of an NP Practice Conceptual Model, a number of advanced practice nursing (APN) and nurse practitioner practice models were reviewed and found lacking in different ways (Spross & Lawson 2005). A very small number of the models reviewed were Canadian and, consequently, did not adequately address Canada's unique health-care system, including its context, identity, strengths or challenges. Therefore, a conceptual model of NP practice was created based on the literature review and consultations (i.e., the round table consultations, colloquium and workshops).

To think about NP practice, it is important to consider and examine a number of elements such as the NP, the NP's unique subject matter, the individuals, communities and/or populations served by the NP, and the places -- and nature of those places -- where NP practice occurs. Over time and with continued commitment to professional development, knowledge levels expand with respect to clients and the complexity of their needs, the body of knowledge of the discipline, and complex systems and contexts that affect the practice environment.

Therefore, a conceptual model evolved outlining essential components. *Health*, the outcome of nurse practitioner practice, is at the centre of the model. The *discipline* is the foundation of practice and contains the body of knowledge and the self-regulatory processes for the profession of nursing. *Patients* are the collaborators and recipients of care. *Context* refers to the immediate milieu in which NP practice occurs, and *nurse practitioner* describes the NP as a population group. Permeable lines that comprise 'society' and 'evidence-based professional practice and inquiry' as well as the 'Canadian health-care system' encompass the core of the model. This NP Practice Conceptual Model is illustrated in Figure 1 (full description is found in Appendix A).

The NP Practice Conceptual Model builds integrally on the work completed by the Canadian Nurse Practitioner Initiative (CNPI) (2006) on the logic model and the **P**articipatory, **E**vidence-based, **P**atient-focused **P**rocess for **A**dvanced practice nursing (PEPPA) framework (Bryant-Lukosius & DiCenso 2004) to support the integration of NPs into the health system.

Figure 1: NP Practice Conceptual Model



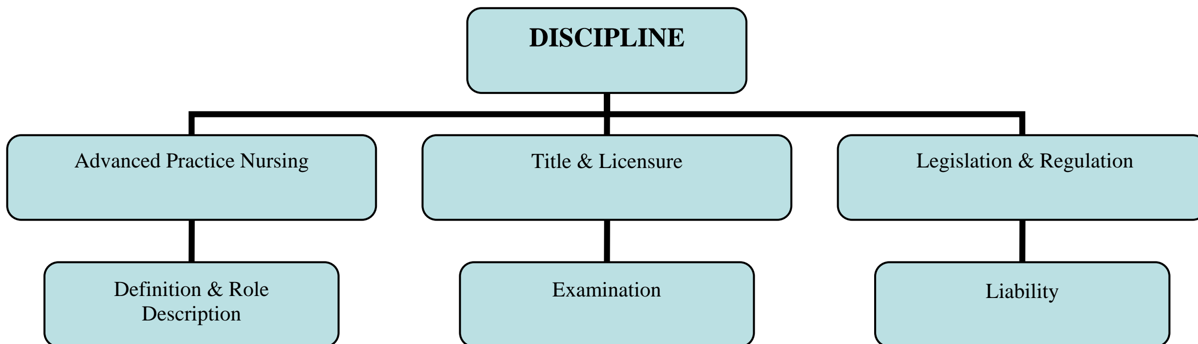
The following discussion of the conceptual model explores each essential component in greater detail.

2.1. The Discipline

The discipline is the component and subject matter upon which education is built and to which health human resources planning, legislation and regulation contribute. In both the logic model and PEPPA framework, the nursing profession and advanced practice nursing community are central to the practice of NPs. In the PEPPA framework, the nursing profession and advanced practice community have responsibility to define and clarify the language, define standards of NP care and NP competencies, define a model of advanced practice, implement NP education programs and evaluate NP outcomes.

A pictorial representation is shown as Figure 2.

Figure 2: Discipline Element of the NP Practice Conceptual Model



2.1.1. Advanced Practice Nursing

The term advanced practice nursing or APN has been used by the nursing profession for decades to describe nurses with advanced education and competencies in the field of nursing. However, there remains confusion in the nursing community regarding the meaning of the term, and toward the scope and role of APNs (Bryant-Lukosius, DiCenso, Browne & Pinelli 2004). This problem is not unique to Canada. In the United States (U.S.) for example, the confusion over terms used to define advanced nursing practice of which NPs are a part, has been identified as 'contributing to a regulatory quagmire' (Lyon, 2005). Despite numerous studies illustrating the significant contributions that APNs have made to enhancing quality care and improving health outcomes, sustaining the role has proven to be a challenge. Variability in title, scope and role has contributed to this vulnerability. Alcock (1996) suggests a need for consistency in advanced practice titles, standards and education to enhance protection of the public and the advancement of the profession.

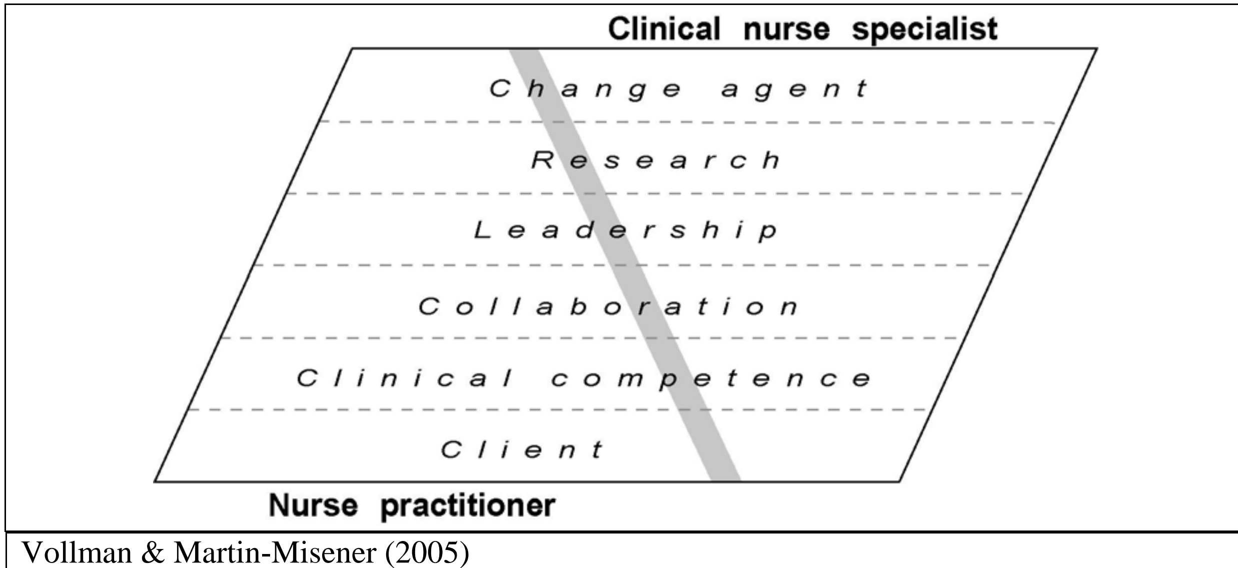
The CNA has developed a framework for Advanced Nursing Practice which identifies five key competencies for advanced practice. They are:

- change agent;
- research;
- leadership;
- collaboration; and
- clinical competence.

According to Roschkov, Urquhart, Rebeyka & Scherr (2004), and as shown in the following Figure 3, the clinical nurse specialist (CNS) and the NP "functions in each domain differently and with varying degrees of expertise" and the percentage of time spent in these roles also varies. The CNS role is usually described as focused on an explicit patient population, provides expert nursing care for that population, implements staff development programs, and facilitates system changes. The CNS may spend little time providing direct clinical care.

NPs, on the other hand, spend the majority of their time in clinical care with a broad base of clientele (Fahey-Walsh 2004).

Figure 3: Competencies of ANP Related to NP and CNS Roles



Vollman & Martin-Misener (2005)

2.1.2. Definition and Scope of Practice

Clear role definition and differentiation from that of other providers are key enablers for the integration of NPs into the primary health care system (IBM 2005). It is believed that a clearly defined role for NPs could allay confusion and ensure understanding by the public and other health professionals (Schreiber et al. 2003).

Role clarity is important among the public and other health professionals with respect to expectations for the NP role, including identification of overlapping or complementary skills and/or scopes of practice. Tarrant (2004) found that understanding NP role and scope of practice facilitates decision-making both with respect to skill mix on the front line and also in the broader arena of health human resources planning. Physicians express uncertainty about what to expect from NPs, their educational preparation for the role, and felt some degree of mistrust; that is, they perceived NPs as physician replacements. Similarly, NPs reported experiencing mistrust and concern about boundary or scope issues from physician colleagues.

The lack of standardization in NP practice has a number of adverse implications. For example, there is lack of role clarity when the description of NP practice varies from jurisdiction to jurisdiction or when a common pan-Canadian title is not agreed upon. Other professionals working with NPs, or patients and families receiving care from NPs have stated that they do not understand what NPs can do (i.e., the NP scope of practice), or what the difference is between an RN–NP, RN (EC), RN (EP)[2] or an NP. There is confusion

[2] RN (EP) or Registered Nurse (Extended Practice) in Manitoba.

respecting the levels of service provided by NPs in remote or rural practice settings as compared to NPs working in urban settings.

As long as the term *nurse practitioner* means different things to different people, role clarity will be elusive, as will attempts to build trust and recognition of the 'NP brand'. It is therefore imperative that the role of the NP be clearly defined and understood in order to enhance stakeholder acceptance of NPs.

2.1.3. Title and Licensure

Two recent discussion papers (Fahey-Walsh 2004; Mayne 2005b) described NP scope of practice in provinces and territories in Canada (Appendix B and C). Each paper identified nine different titles and designations used in existing and pending legislation in Canadian jurisdictions. For example, designations for the NP varied from NP–PHC, PHC–NP, NP, RN (EC), RN (EP), RN (NP) and NP. Consistency in title is important in facilitating public, employer, and other health professional understanding of the purpose, role, and scope of practice of the nurse practitioner role (Offredy 1999).

A recommendation for a single approach to licensure was formulated (Vollman & Martin Misener 2005b). This approach was found to be familiar, affordable, sustainable, acceptable and portable. In subsequent papers by Mayne (2005b) and Gelder (2005), the single licensure approach was further explored, with arguments for a single approach debated and subsequently recommended in both papers (Appendix for C and D). However, the goal of a single approach to licensure is particularly challenging for NPs in Canada because the NP role has evolved over time subject to various jurisdictional considerations and regulatory frameworks. For some, there is also a belief that there is not a generic NP nor is it beneficial to pursue this approach. A single approach to licensure, however, would underpin a single national title protected by each Canadian provincial and territorial jurisdiction.

In addition to the varied licensure approaches among jurisdictions, there have also been reservations expressed by RNs working in expanded roles and by their employers/administrators concerning the implications and impact of a national framework to NP licensure on their particular situations. Often these nurses are working in rural, remote, isolated and/or northern areas that have difficulty recruiting and retaining health-care professionals. There is a willingness and acknowledgment for the need for a standard licensure approach. As well, these nurses welcome the opportunity to gain more knowledge. However, to meet the requirements for licensure issues have been raised regarding the ability to replace/relieve these RNs in order to return to school to meet the requirements. This may be an extremely difficult task, if not impossible in some situations.

It is important to provide opportunities for registered nurses to meet new NP licensure requirements if appropriate. For example, it has been suggested that a transition period be instituted to allow nurses an opportunity to meet the requirements for licensure. These nurses, their employers, the jurisdictional regulatory bodies and governments need to work in concert to not only facilitate the transition of RNs to become NPs, but also to ensure that health care services continue to be available and accessible to communities they serve. A key question

that needs to be considered and addressed to inform the licensure process respecting these nurses concerns whether all of RNs working in these types of settings need to become NPs.

2.1.4. Examination

To support a single approach to licensure, a single national examination process is warranted. Based on the pan-Canadian core competencies, a national exam 'Family – All Ages' was developed by the CNPI (please see the Legislation and Regulation Chapter of this report for more detail).

2.1.5. Legislation and Regulation

Legislation and regulation play a role in ensuring the legitimacy and enabling the practice of health professionals. They are intended to serve and protect the public's interest, are based on the premise that regulated health professionals deliver higher quality care (Bohnen 1994), and can either enable or create barriers for the professionals to practise to their full scope.

In the absence of a pan-Canadian framework, provinces and territories have implemented their own methods to regulate NPs in response to unique provincial/territorial needs. These differences have resulted in diverse approaches that impact the mobility of NPs to move across areas of practice and inter-provincial/territorial boundaries and the ability of NPs to work to their full scope of practice. Some examples of activities or services that NPs are prevented from implementing in all or some jurisdictions include:

- prescribing controlled substances;
- completing federal government documents such as maternity leave and pension plan disability forms, as well as passport applications;
- working autonomously with hospital in-patient populations;
- completing third-party payer forms; and
- completing provincial forms such as disabled parking permits.

Restrictions created by other relevant professional acts must be identified and examined to determine the effect on NP practice and addressed to eliminate the barrier that impedes practice. If, for instance, legislation that governs the practice of pharmacists, diagnostic imaging or laboratory technicians, etc. prohibits NPs from filling prescriptions, or carrying out diagnostic tests, the discipline needs to take action to address these barriers.

2.1.6. Liability

It is identified that for NPs in Canada, there are very few gaps in liability protection. In fact, at times there is duplication in liability protection for the NP which suggests inefficiencies. Often this duplication has come not from substantive evidence regarding the liability of NPs, but from pressure from government and other health-care provider groups. If there is duplication of liability protection, then our health-care dollars may be better spent rationalizing the protection available or ensuring that duplication is not being forced upon the NP.

In Canada today, NPs in good standing with their member association at the time of an incident are eligible for personal, occurrence-based professional liability protection in the amount of $5 million per incident with an annual aggregate of $5 million (CMPA and CNPS, 2005). In some jurisdictions, liability protection for some health-care providers is covered by the government, although this is not the case for NPs. As team-based care becomes the norm in health delivery across Canada, governments should consider liability coverage for all members of the team.

Way and Jones (2004) expressed concern around remuneration and medico-legal liability as they relate to interprofessional practice, not only with physicians but also with other professional groups. Physicians are reportedly concerned about their liability when NPs independently care for patients. The specific area of concern is about insurance coverage, its adequacy, vicarious liability (Jardali 2003) and the application of tort law (Lahey & Currie 2005). Way and Jones (2004) further reported concerns about interprofessional collaboration and how courts will determine and/or allocate liability in situations where multiple care providers are charged with negligence. Lahey and Currie (2005) propose that the move to interdisciplinary care teams is based on the premise that increased collaboration will lead to improved care and as a result there would be decreased liability as a whole

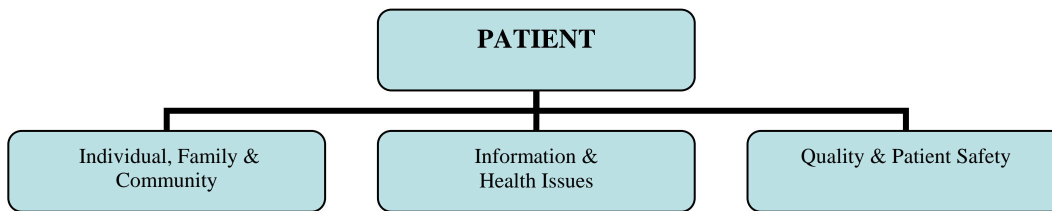
The appropriate level of NP professional practice and liability protection must be determined by a risk analysis that includes data on malpractice payments and adverse actions of NPs and comparing these to data on other health-care provider groups to assess the relative risk posed by NPs (Mayne 2005a). It has been suggested that a national database similar to the U.S. be established in Canada to track claims.

2.2. **The Patient**

The rationale for implementing the NP role at the local, provincial/territorial, or national levels and for the activities of the discipline is directly related to the needs of the patient population. Patients, as recipients of care, come from diverse backgrounds, span a large age range, have a variety of health needs and coping skills, and live within social contexts.

A pictorial representation is illustrated in Figure 4.

Figure 4: Patient Element of the NP Practice Conceptual Model



2.2.1. Individual, Family and Community

The *CNA Framework* (2002) depicts patients as individuals, families, groups, aggregates, communities and populations. Individual NP practices can focus on any of these patient groupings, or a combination of groupings. NPs value community involvement and practise from a population health viewpoint incorporating the determinants of health into their work. NPs are often the first point of contact for many patient groups with the health system.

Patients expect to receive accessible, competent, ethical care from nurse practitioners. They expect NPs to listen and address their concerns with compassion, taking into consideration the multiple realities of their complex lives. Patients expect to be treated as partners in their own health care and to have the ability to choose an NP as their health-care provider. Patients are participants in decisions about health-care planning and this should include involvement in assessing the need for a nurse practitioner in a given setting.

2.2.2. Information and Health Issues

To maximize the contribution of NPs to overall health of patients and patient care, it is imperative that NPs are aware of, and have access to, a variety of health information sources that include broad population health perspectives. Regardless of the patient mix, the NP requires and utilizes health data such as health assessment and evidence-based guidelines, laboratory and diagnostics supports, and e-pharmaceuticals support etc., to support decision-making and facilitate the provisions of safe, competent and high-quality care.
For example, databases and information sources may range from population health statistics, information databases on prevailing health concerns in the practice settings, health records, and other data on the health, capacity and social capital of the individuals, families and communities served by NPs. Consideration of each of these information sources as appropriate is integral to quality care and patient safety (please see the Health Human Resources Planning chapter for more details).

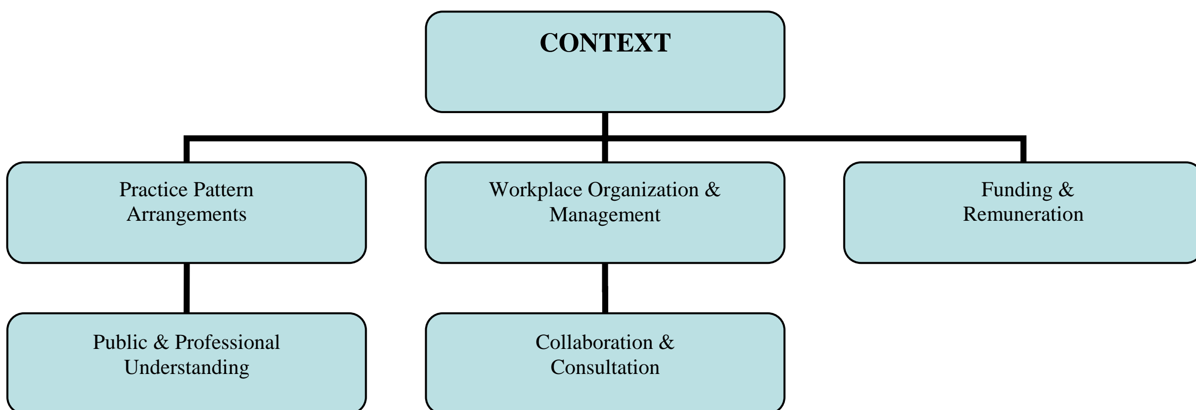
2.2.3. Quality and Patient Safety

In all aspects of health-care service, patient safety is a critical element and an expectation by the public from health-care providers. This public expectation is no different for NPs. People place their trust in providers when they are at their most vulnerable, when they are seeking information and assistance with prevention of injury and disease, when they want to take action to promote health, and when they need assistance with rehabilitation or palliation. They expect safe care that is of high quality and based on best practices. The need for legislation and regulation is most commonly justified as being protective of the public and assurance that providers are safe to practice.

2.3. **Context**

The context refers to the immediate milieu in which NP practice occurs; that is, the settings where NPs carry out their work. This context influences NP practice and this influence must be considered from the NP, patient and co-worker points of view. The context includes the setting, management, authority and accountability processes, as well as the organizational structure by which NPs interact with patients and other professional colleagues. As well, context includes policy issues which can directly enable or detract from the integration and sustainability of the NP role. A number of enabling policy issues were identified regarding health human resources planning, education requirements for NPs, quality management and outcome performance, as well as funding model reform.

Figure 5: Context Element of the NP Practice Conceptual Model



2.3.1. Practice Pattern Arrangements

There are many practice pattern arrangements in which NPs provide health services. The literature, including Canadian research, suggests that some of the key concepts in these arrangements or models are:

- the nature, needs and priorities of the patient;

- the focus and scope of services provided by the NP;
- the context, including geography, availability of resources, roles of other health-care team members, employer policies and supports;
- legal and regulatory requirements;
- how collaboration, consultation and referrals occur internally in the setting among team members and externally to other health-care providers, organizations or levels of care;
- availability of information systems such as electronic health records, Telehealth, Internet, etc.; and
- models for funding and remuneration.

The following are examples of models of care being used in Canada today. It is evident that the variety and scope of the settings and the nature of the populations served are diverse:

a) *geographical settings* – remote; rural; urban
b) *institutional settings* – community health centres; long-term care centres; community hospitals; ambulance transport; nursing stations; family practice offices; home care services; student health services; mental health settings; correctional facilities; academic practices; emergency rooms; among others
c) *populations* – all-ages primary care; lower socio-economic groups; aboriginal populations; people with chronic diseases; students; employees; among others
d) *practice configurations* – solo (independent) practice; interdisciplinary teams; legislated collaborative agreements; consultative models; interprofessional practice; among others

Drawing from the NP narratives, nurses working in remote communities talk about having to wait for a doctor to arrive at the clinic every eight weeks in order to address requests for mammograms that the NP who practices in the south under more formal NP legislation could refer or requisition independently. The lack of legislated authority to perform procedures, make diagnoses, and write referrals and prescriptions was the barrier most often cited in terms of context (Appendix E).

The future may bring fewer health human resources to meet the increasing demands for care from elders who are living longer with chronic conditions, aging in place[3], and requiring greater need for technology and support in the community.

2.3.2. Public and Professional Understanding

The patient/public lacks understanding of the role of the NP and the benefits the NP can bring to accessing care and enhancing health.

It has been identified that the structure of the physician and NP relationship can be either a strong asset or barrier to NP integration. Corroborated by the IBM study (p. 105), the highest levels of satisfaction identified by the NP were for the respect shown by the NP and the

[3] 'Aging in place' means staying in own home rather than living in assisted-living facilities/institutionalized settings such as nursing homes.

family physician(s) (FP) in each others' knowledge and skills and the trust shown by the NP and FP in each others' ability to make shared decisions about patient care. Also valued was the open communication that takes place between the NP and the FP regarding patient care decisions. Perceptions which categorize NPs as 'doctor assistants' prevail. These perceptions are detrimental as they demonstrate a lack of understanding of the NP role, do not recognize the NP legal scope of practice or the autonomous and collaborative nature of the NP role. While concepts of NPs practising autonomously and collaboratively are common across the country, expectations for collaboration and consultation vary significantly. Collaborative practice can mean the NP practice is limited by a legal formal practice agreement as specified in legislation which restricts autonomous decision-making or can mean a broad open model where the NP drives the amount of collaboration and consultation based on client needs and practitioner knowledge. Limitations placed on scope of practice and decreased independence and autonomy in NP decision-making can lead to dissatisfaction and conflict, and hinder the ability of the NP to successfully implement his/her role (Sidani, Irvine & DiCenso 2000; Woods 1997).

In the narrative study the relationship between the NP and others – the physician in particular – had an important impact on the way that the NP defined her/his practice. Developing relationships over time was essential in building trust and allowed the NP to feel that she/he was practising within the full scope possible in that particular setting and province/territory. In many narratives the participants talked about being "tested" by physicians in order to establish credibility. Some physicians claim to be unhappy with NP role preparation and knowledge base, and view collaborative practice as time-consuming, disruptive and potentially 'de-skilling' for themselves.

Physicians who have not practised with an NP do not understand the role; those physicians that have practised with an NP are clearer about the role and its contributions to the health-care system. The former group of physicians may fear they are being asked to change their practice behaviours to accommodate NP practice, creating tension and slowing the pace of change to collaborative practice models. These factors are affecting physician-NP relations at the front lines, relations at the association levels, and creating tensions around professional legislation and regulation in many jurisdictions.

2.3.3. Workplace Organization and Management

Other contextual factors are played out at the employer agency level. At the organizational level, questions regarding responsibility for and management of NPs are unclear. In many work settings, job descriptions may not be clear and performance benchmarks for quality care have not been determined. Setting-specific policies regarding coverage of weekend shifts, statutory holidays and sick time need to be developed, and continuing education, remuneration, and other employment issues need to be more standardized. Further, orientation packages that include specific information on policies, procedures, etc., are helpful for both the NP and for the other professional disciplines interfacing with the NP on a regular basis.

To support the integration of NPs into work settings, a needs assessment and clear definition and description of the proposed NP role for the location should be undertaken in concert with NPs. This will assist the organization in articulating the purpose, goals and team strategy and optimize the scope of practice of all providers involved. Clarity respecting roles of RNs working in extended practice, NPs, and physicians is paramount for interprofessional collaboration. Conflict resolution strategies should be in place at the outset to minimize any disruptions in service or teamwork caused by lack of clarity or personal misunderstandings.

Within organizations, communication routes and documentation standards within nursing and across departments should be clearly specified, including the development and use of risk management tools.

Practical tools have been developed to specifically address these important issues and can be found in Section 1: Chapter 5: Tools.

2.3.4. Collaboration and Consultation

Collaboration is a process that requires interactions between people, interdependence, and a sharing of knowledge and expertise between professions that have typically worked independently (Henneman, Lee & Cohen 1995). “Collaborative practice is an interprofessional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided” (*Interprofessional Education for Collaborative Patient-Centred Practice* (IECPCP), Health Canada).

As identified in this review and others, as provinces, territories and health authorities move forward on primary health care reform, all team members including physicians are required to change their practice behaviour to accommodate the interprofessional team.

Seven elements have been identified as being essential for optimum collaboration (Weiss & Davis 1985; Baggs 1994; Norsen, Oplen & Quinn 1995). They are:
- co-operation;
- assertiveness;
- responsibility/accountability;
- autonomy;
- communication;
- coordination; and
- mutual trust and respect.

2.3.5. Funding and Remuneration

Two issues become apparent with respect to funding and remuneration: funding models of care and NP funding. Funding models of care (i.e., fee-for-service models) is a significant issue impacting the successful integration of NPs. The lack of sustainable funding and/or

reimbursement models is a barrier to the evolution and integration of NPs. Funding model reform should support team care and ensure money follows the patient versus the provider.

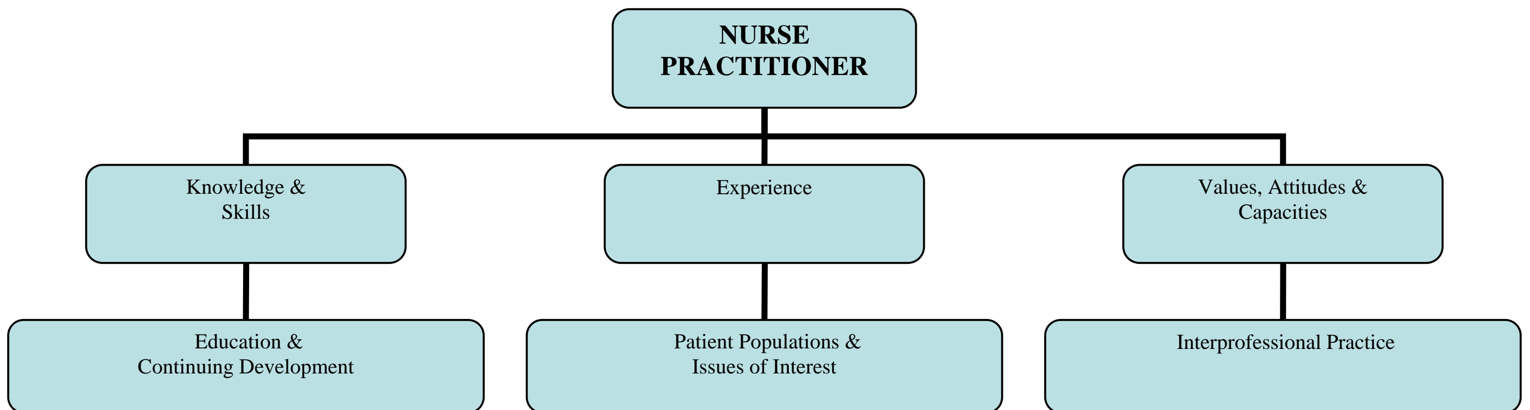
The second issue is specific to the funding of NPs. Economic and financial barriers are significant to NP implementation. A policy for stable funding mechanisms that allows for equitable salaries among settings and work sites, leave policies, and overhead coverage is needed. In addition, billing rules, processes for drug prescriptions, requisitioning laboratory tests, and referral policies must be addressed.

There are gaps in the supports required for the integration of NPs into the health-care system. For instance, the impact of funding models for capital costs, infrastructure, technology, electronic health records, billing (remuneration) for services, and continuing education support. The need for collaborative teams to have consultation time cannot be addressed in a solely fee-for-service model. Stakeholders, including administrators and NPs, need to be aware of the need for relief or locum practitioners for NP sick and holiday time, time for updating education and competencies, and time for teamwork and consultation.

2.4. **Nurse Practitioner**

Full utilization of the NP role and scope of practice to meet population health needs is dependant on the discipline, a 'fit' between the NP role and patient population needs, and maximizing contextual facilitators.

Figure 6: Nurse Practitioner Element of the NP Practice Conceptual Model



2.4.1. Knowledge and Skills

It is important to understand the expectations of nurse practitioners as a population – what they know, what they have experience in doing, what skills they hold, how flexible they are in terms of learning new ways of carrying out their nurse practitioner skills, their values, attitudes and capacities. We need to understand how they are likely to interact with colleagues, with patients, and with one another. As well, time as a mediating factor is integral to an understanding of the development of NP expertise and interdisciplinary team development that occurs over time.

The role of NP has suffered from a lack of clarity because jurisdictions have under provincial and territorial authority written their own definitions, determined respective scopes of practice, and set educational requirements for role preparation and performance standards for NPs. Additionally, federal, provincial and territorial government and associations/regulatory colleges have similarly differentiated between NPs and other APN roles. Also provincial/territorial legislation identifies the educational approval, review and recommendation processes required for NPs. This makes stipulating national-level characteristics for NPs a difficult task.

The basic preparation for the NP is founded upon a set of agreed-upon pan-Canadian core competencies that all NPs will demonstrate (CNA 2005). These core competency statements describe the minimum requirements with respect to the integrated knowledge, skills, judgment and attributes required of an entry-level NP to practise safely and ethically in a designated role and setting, regardless of patient populations or practice environments. The 78 core competencies build on the competencies required of a RN. In other words, the NP exhibits the competencies of a RN and the competencies of the NP. There are four categories of NP core competencies: health assessment and diagnosis; health-care management and therapeutic intervention; health promotion and prevention of illness, injury and complications; and professional role and responsibility.

NPs have the ability to practice in a variety of settings, with multi-faceted clinical role skills, often in ambiguous and/or complex situations where they need to use complex reasoning, critical thinking and analysis to inform practice, judgement, and decision-making. Hence, the NP must be an independent learner who is continually seeking new understandings through a variety of means to reflect critically on practice. The NP also has well-developed communication, negotiation and conflict resolution skills that foster the ability to demonstrate leadership in planning, implementing and evaluating interventions; plus provide care to a variety of clients (individuals, families, aggregates, populations, and communities) by engaging patients in care. It is important for NPs to work at multiple systems levels to get to the root of the problems that surface.

2.4.2. Education and Continuing Development

All licensed NPs in Canada either are graduates from NP programs or have successfully completed a prior learning assessment recognition function (PLAR). Because the NP is an advanced practice role, to be congruent with the APN framework and to be consistent with the recommendations of the education component, a master's level preparation should be required to become an NP.

Education prepares NPs to incorporate a nursing framework into their advanced practice and to embrace a holistic approach to the care they provide. Through their educational experiences and clinical practice, NPs learn to integrate research and new knowledge into their NP practice and management, become open to diversity in terms of patient populations and settings, and increase their focus on enhancing positive outcomes by using a client-centred evidenced-based approach. Because NPs base their practice on evidence and research, provisions for ongoing continuing education and professional development are key to quality care and public protection.

2.4.3. Experience

NPs are experienced RNs who engage in reflective practice as they carry out the additional functions of the NP role. Early in their practice, NPs focus primarily on consolidating competence and building confidence; more of the other ANP domains of practice are fully engaged with time in the role. As confidence and competence builds over time, the need to consult decreases while the imperative to collaborate on more complex situations increases. Knowledge and experience are the foundation of expertise. To enhance and maintain competency, NPs require on-the-job access to Internet resources, online consultation, and ongoing continuing education opportunities.

2.4.4. Patient Populations and Issues of Interest

NPs act as advocates for all groups that they work with and especially for marginalized populations, on controversial issues, and in unpopular settings. Some populations do not respond well to traditional provider-patient relationships and in these circumstances an NP may be an appropriate choice as an alternate care provider.

2.4.5. Values, Attitudes and Capacities

NPs assume responsibility for how they want to practise in the context of their jurisdictions. NPs practice according to the standards and ethics of nursing. Their experience and additional education give them the capacity to provide a high level of care, and hence, increase access to health services for Canadians. They are confident that they can as NPs make a positive contribution to the Canadian health-care system and to the health of Canadians.

2.4.6. Interprofessional Practice

NPs express willingness to share power and influence and to embrace the intra- and interprofessional work that is necessary to facilitate collaborative care and facilitate positive patient experiences and outcomes. NPs value the need and ability to work in concert with a diverse range of providers, acting as a link or conduit between the medical/nursing/community worlds to enhance and improve quality of care. NPs embrace the concept of collaborative practice across disciplines and sectors, and see themselves as developers and sustainers of health-care teams.

A review of the evidence linking care provided by NPs with patient outcomes, quality of care and resource utilization consistently demonstrated that NPs provided attentive, comprehensive, and high-quality health care comparable to care provided by physicians. Based on this evidence, the sustained implementation of NPs in the health system will increase Canadians' access to quality, safe and appropriate care.

2.4.7. Evidence-Based Practice

Health-care guidelines are "systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances" (Institute of Medicine 1992). Evidence-based guidelines are quality-improving strategies that bring together the best evidence necessary to assist in clinical decision-making about specific health issues. These guidelines facilitate or guide health professional practice and help ensure safe, competent and ethical care is provided to the public served.

Many organizations have developed clinical practice guidelines for a variety of clinical foci and a variety of professional disciplines. These guidelines are usually developed through a consensus-building process, and reflect the best evidence and opinion at the time of their development. Evidence-based clinical guidelines are also subject to revision as knowledge emerges and experience advances.

2.4.8. Health-Care System

Literature reviews revealed the following health-care system and environmental factors impacting NP practice:

- Lack of a national legislative regulatory framework has enabled inconsistencies to develop across jurisdictions; legitimacy of the NP role and public safety are the key reasons making a national approach to NPs imperative.
- Without sustainable funding, appropriate reimbursement models, and quality assurance/improvement models, health human resources planners cannot successfully interpret or respond to supply and demand issues in current times of scarce resources.
- Cultural and historical bases for health-care funding and delivery in Canada, attitudes about and by other health professions, and lack of understanding by the public are hampering health-care reform and the emergence of an appropriate place for NP practice.

3. RELATED RECOMMENDED ACTION STATEMENTS

Elements	Related Recommended Action Statements
Advanced Nursing Practice	Revise the CNA advanced nursing practice framework to reflect and clarify the role of the Nurse Practitioner
Definition and Role Description	Adopt the following nurse practitioner definition and role description: Definition: **Nurse practitioners are registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice.** Role Description: **"Nurse practitioners are experienced registered nurses with additional education that have achieved the competencies required for nurse practitioner registration or licensure in a province or territory. Using an evidence-based, holistic approach that emphasizes health promotion and partnership development, nurse practitioners complement, rather than replace other health-care providers. Nurse practitioners, as advanced practice nurses, blend their in-depth knowledge of nursing theory and practice with their legal authority and autonomy to order and interpret diagnostic tests, prescribe pharmaceuticals, medical devices and other therapies, and perform procedures. They carry out these actions for the purposes of: 1) diagnosing and/or treating acute and chronic disease; 2) promoting, protecting, maintaining, rehabilitating or supporting health; 3) preventing illness or injury; and 4) supporting end-of-life care."**
Liability	• Establish a national voluntary database to track claims and payments made against NPs • Provincial/territorial governments cover the costs of liability protection
Collaboration and Consultation	Incorporate the seven elements deemed essential for optimum collaboration into all practice arrangements, including existing agreements
Interprofessional Practice	Develop and implement clear policy direction for models of interprofessional Primary Health Care service delivery and a supportive change management strategy

4. **CONCLUSION**

Multiple barriers to the sustained implementation of NPs in Canada have been identified and reviewed. *The Practice Framework for Nurse Practitioners in Canada* is intended to mitigate these barriers and support full and effective integration of NPs. It has at its core a commitment to a basic underlying conceptual model. This model is comprised of components, including the NP, context, patient and discipline. It also includes five specific, related recommended action statements for advanced nursing practice, definition and role description, liability, collaboration and consultation and interprofessional practice which need to be considered to sustain the NP role. The NP Practice Conceptual Model has been developed to provide a pan-Canadian approach to understanding NP practice and, if followed, offers a thoughtful planning framework for positive and sustained outcomes.

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