Advanced Nursing Practice: Opportunities and Challenges in British Columbia

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The nurses and health care employers of British Columbia

The nurses, physicians, patients, and other participants at the five case study sites

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Key Implications for Decision Makers

- British Columbia should foster two advanced nursing practice roles by supporting the “clinical nurse specialist” and establishing the “nurse practitioner.”

- New money should be allocated to health authorities for advanced nursing practice positions and to provide for infrastructure and organizational support of advanced practice nursing.

- Government and professional associations should fund and develop a public education campaign to educate and market advanced nursing practice roles to the public, policy makers, and other providers.

- Legislation, regulation, and deployment of advanced practice nurses should not occur in British Columbia unless and until there is stable funding to support implementing and sustaining the role.

- Employers and nurses in British Columbia identified health promotion, illness prevention, chronic disease management, primary care, mental health, and geriatrics as areas in which advanced practice nurses could be used.

- In other jurisdictions, physician shortages, gaps in services, and political will were generally associated with the setup of advanced nursing practice roles.

- Effective advanced nursing practice roles can be established in British Columbia by developing and implementing legislation and regulation that:
  
  o is consistent with the Canadian Nurses Association framework;
  o protects the titles “nurse practitioner,” “clinical nurse specialist,” and “advanced nurse practice;” and
  o enables a professional practice model in which practitioners have sole authority for their practice, clear standards of practice, accountability for decision-making, and skill maintenance and development.
Executive Summary

This project supports decision-making and policy development around new and emerging nursing roles and service delivery models within British Columbia. The main project question was “What can registered nurses practising in new and/or advanced roles contribute to health and service delivery needs in British Columbia?”

Registered nurses in British Columbia should be able to practise in two advanced nursing practice roles — “clinical nurse specialist” and “nurse practitioner.” Clinical nurse specialists are registered nurses, usually at the graduate level, who demonstrate excellence in a focused area of nursing practice and are role models and advocates for quality healthcare. They also provide leadership and act as clinicians, consultants, educators, and researchers. Nurse practitioners are registered nurses who have achieved the level of education required for additional registration as a nurse practitioner with the Registered Nurses Association of British Columbia. Nurse practitioners’ skills are usually learned through graduate nursing education and substantial nursing practice experience. Nurse practitioners provide healthcare services from a holistic nursing perspective combined with a focus on the diagnosis and treatment of acute and chronic illnesses, including prescribing medications.

“The nurse practitioner role greatly benefits doctors’ practice because patients need a great deal of support for symptom management and docs are simply not prepared to do it, either in terms of time or up-to-date knowledge.”

– radiation oncology physician

Legislation, regulation, and deployment of advanced practice nurses should not occur, however, until stable funding to support implementing and sustaining the advanced nursing practice role is in place. Government and professional associations should fund and develop a public education campaign to educate and market advanced nursing practice roles to the public, policy makers, and other providers. Further, new money should be allocated to health authorities for advanced nursing practice positions and to provide for infrastructure and organizational support of advanced practice nursing, particular skill development, and maintenance needs. New money should be allocated to universities to support development of appropriate educational programs to prepare faculty to teach in these programs and to support continuing education. As well, funding reallocation needs to be explored to support salaried advanced nursing practice. Funding models to support the development and sustainability of advanced nursing practice also needs to be explored.

Legislation and regulation of advanced practice nurses should be set up using a professional practice model in which practitioners have sole authority for their practice, clear standards of practice, accountability for decision-making, and maintaining skills. As well, legislation and
regulation should protect the titles “nurse practitioner,” “clinical nurse specialist,” and “advanced practice nurse.” Educational preparation for entering advanced nursing practice should be at the graduate level in nursing appropriate to the competencies required.

Advanced nursing practice is not new to B.C. The research team found that registered nurses in B.C. who were interviewed for this study say they are already practising in an advanced role, although the degree to which their practice was congruent with national standards was variable. Nurses’ understanding of their role was related to their level of formal education. The majority of nurses think their knowledge and skills are underused due to limitations on scope of practice, restrictive job descriptions, and/or multiple demands on time. In their opinion, advanced nursing practice could be expanded in health promotion, illness prevention, and chronic disease management with a broad range of population groups, as well as in specific clinical areas such as primary care, mental health, and geriatrics. Almost all nurses included in the study thought advanced nursing practice should require practice experience and formal education, but they differed on the level of formal education they recommended.

“We work really well as nurses first and nurse practitioners second with chronic illness, which nobody likes to manage. We do a good job with that. We help people look, maybe accept, maybe work through, maybe get to a point where they can manage themselves. And we’re more patient about it [than physicians]. We take the patient’s perspective. So we’re probably the better people to be doing that kind of work, in consultation with a physician.”  
– advanced practice nurse

Employers also endorsed creating advanced nursing practice roles. More than 70 percent of the employers surveyed said they already had nurses in advanced practice roles, and 30 percent said they intended to hire more nurses in such roles in the future. Employers reported a need for clinical nurse specialists, particularly in practice areas where gaps in service were reported, such as primary care, geriatrics, and mental health. Lack of funding was reported as the most common barrier to implementation. Nurse practitioners were seen as most needed in primary care and palliative care. Barriers to implementation included lack of funding, lack of availability of qualified advanced practice nurses in B.C., physician resistance, and restricted scope of practice.

Employers in urban areas placed a higher priority on having clinical nurse specialists in medical and surgical care units and in pediatric care. They also rated the importance of research skills more highly. Employers in rural and remote areas identified public resistance as a bigger barrier to implementation of advanced practice roles than did employers in urban areas.
Other jurisdictions (Ontario in Canada and Washington State in the United States) that have advanced nursing practice roles were studied and models identified. In all sites that were studied, advanced nursing practice roles developed as a result of the union of three factors: physician shortages, gaps in service, and a welcoming political climate. Other providers and patients saw nurses in advanced nursing practice roles as providing good quality care that met patients’ needs, and there was a high degree of satisfaction with the care they provided. Nurses in Ontario and Washington who are licensed and recognized as advanced practice nurses were more congruent than B.C.’s nurses in their understanding of advanced nursing practice, although the latter function as but are not yet licensed or recognized as advanced practice nurses.

“To me, I think you’re bringing a composite of nursing care, nursing skills, together with a happy blend of what I would call global care, holistic care to the patient, which takes in both the nursing and the medical aspects into a single whole. They bring to the role the whole background and philosophy in terms of nursing and certainly the sensitivity and caring that goes along with nursing, the nursing skill and then, in fact, blend that into the medical care of the babies by performing a very essential role in terms of composite, if you like, total family-centred care... It’s very different for the physician, I think...”

– neo-natal physician

In order to develop these findings and recommendations, the project was conducted in three phases. In Phase 1, we studied what the current status, understanding, and need for advanced nursing practice roles in B.C. are. Nurses who identified themselves as clinical nurse specialists provided their opinions through e-mail and telephone surveys and focus groups. Employers’ opinions were gathered through e-mail surveys. In Phase 2, we explored “what could be” by conducting case studies of six models of advanced nursing practice in five sites in Ontario and Washington. In Phase 3, we defined in some detail “what should be,” related to advanced nursing practice in B.C. To develop this vision, nurses, physicians, other providers, employers, researchers, policy makers, educators, and representatives of professional organizations participated in a two-day think tank.

Additional research should be conducted on evaluating the implementation of nurse practitioners within B.C. Further, the feasibility of adopting nurse anaesthesia as an advanced nursing practice role in Canada should be explored.
In this statement of findings, we present the context, implications, approach, and results of the study. We also provide additional resources, suggestions for further research, and references and bibliography.

**Context**

Within British Columbia, interest in advanced nursing practice has been prevalent for several years. Nursing educators were developing certificate and graduate nursing programs that involved some aspects of advanced nursing practice; pilot projects (such as community health centres) were providing opportunities for nurses to work within and at the boundaries of their scope of practice, and the provincial Health Professions Council was reviewing the nursing scope of practice. Many groups were interested in developing legislation to enable advanced nursing practitioners to practise in the province and, even without enabling legislation, the ministry was aware that some health authorities were seeking to hire nurse practitioners. In addition, the Registered Nurses Association of British Columbia, the provincial regulatory body for registered nurses, had developed a position paper on advanced nursing practice, which became a pivotal document in the development of the Canadian Nurses Association’s national framework.

Provincial Ministry of Health (now Ministry of Health Planning) staff conducted a literature review and cross-Canada environmental scan on advanced nursing practice. The reviewers found a large body of literature demonstrating the positive impact of advanced nursing practice on quality and cost-effectiveness of care, while highlighting uneven implementation of advanced nursing practice in the Canadian healthcare system, with the exception of the clinical nurse specialist role. Lack of consensus on the meaning of and requirements for advanced nursing practice within and outside the profession of nursing made it difficult for ministry staff to assess the health system’s need for advanced nursing practice and develop ministry policies to guide the deployment of nursing human resources. Thus, we proposed this research project to obtain data to support decision-making and policy direction on new and emerging nursing roles and service delivery models in the province.

Provincial Ministry of Health staff teamed up with people, primarily nurses, representing decision-making staff in government, the nursing regulatory body, health services employers, and researchers from academia and practice organizations to answer the research question,
What can registered nurses practising in new and/or advanced roles contribute to health and service delivery needs in British Columbia? Three additional questions elaborated upon the main research question: What is advanced nursing practice in B.C.? What could be advanced nursing practice in B.C.? What will advanced nursing practice be in B.C.?

Implications
There are implications of this study for the legislature, various ministries, and professional associations, as well as healthcare administrators, educators, and providers.

Legislators, Ministries, and Professional Associations — The findings of this study provide a framework for the legislature to authorize, the ministries of Health Planning and Advanced Education to develop policy for, and the Registered Nurses Association of British Columbia to regulate advanced nursing practice roles within British Columbia. These roles should include the nurse practitioner and the clinical nurse specialist. Nurse practitioners are registered nurses who have achieved the skills and education required for additional registration as a nurse practitioner with the Registered Nurses Association of British Columbia. Competencies required of nurse practitioners are usually achieved through graduate nursing education and substantial nursing practice experience. Nurse practitioners provide healthcare services from a holistic nursing perspective combined with a focus on the diagnosis and treatment of acute and chronic illnesses, including prescribing medications. Clinical nurse specialists are registered nurses, usually at the graduate level, who demonstrate excellence in a focused area of nursing practice and serve as role models and advocates for quality healthcare. They also provide leadership and act as clinicians, consultants, educators, and researchers. Both these roles should be consistent with the Canadian Nurses Association framework.

Further, legislation and regulation should protect the titles “nurse practitioner,” “clinical nurse specialist,” and “advanced nurse practice.”

The legislation also should enable a professional practice model in which practitioners have sole authority for their practices, clear standards of practice, accountability for decision-making, and skill maintenance and development.
Legislation, regulation, and deployment of advanced practice nurses should not occur in B.C. until stable funding to support implementing and sustaining the role is in place. Government and professional associations should fund and develop a public education campaign to educate, market, and sell advanced nursing practice roles to the public, policy makers, and other providers. Further, new money should be allocated to health authorities for advanced nursing practice positions and to provide for infrastructure and organizational support of advanced practice nursing, particularly skill maintenance. New money should be allocated to universities to support development of appropriate educational programs; to prepare faculty to teach in these programs; and to develop continuing education to ensure ongoing competence. As well, exploration of existing sources of funding for possible reallocation to support salaried advanced nursing practice positions is needed, as well as further exploration of funding models to support development and sustainability of advanced nursing practice.

Healthcare Administrators and Providers — The findings of this study are also applicable to healthcare administrators and providers who will create the atmosphere in which nurse practitioners will work. Administrators and providers must respond to specific challenges and provide support to overcome those challenges. Challenges to be addressed include lack of understanding of nurse practitioners’ role, financial issues (lack of funding, inadequate compensation, and fee-for-service physician practice), and difficulty accessing continuing education, as well as physician resistance, lack of direct authority, difficulties with protocols, and the working environment.

Part of the working environment is professional collaboration, a key feature of advanced nursing practice. Challenges to collaboration come from resistance to advanced nursing practice roles from other providers; inequities within healthcare teams, including payment mechanisms and professional socialization; and lack of understanding of roles. Clear and consistent role definitions to clarify possible misunderstandings regarding collaboration, to distinguish between advanced nursing practice and medicine, and between advanced nursing practice and expert or specialized nursing practice, must be developed.

Challenges to implementation and ongoing enactment of the nurse practitioner role are mainly organization-specific and relate primarily to structures, policies, and cultures within each site. The challenges to role enactment for individual nurse practitioners include lack of
leadership and vision for the role; lack of support for new nurses entering the role; use of medical directives and protocols; managing multiple demands; allowing for protected time for research and other professional activities; lack of a physician colleague for consultation; accessing continuing education to maintain registration; and limitations in the job description to fully enact an advanced nursing practice role.

**Approach**

This project was a three-phase descriptive, exploratory study designed to support decision-making and policy development. Table 1 provides each phase’s question and objectives. For all phases, we used the Canadian Nurses Association framework (“Advanced Nursing Practice: A National Framework”iv) as the conceptual foundation to guide the development of interview questions as well as data collection and analysis.

**Phase I** answered the question, *What is advanced nursing practice in B.C.?* To fulfil this phase’s three objectives, we completed four steps. In Step 1, we conducted telephone interviews and e-mail surveys of 47 self-identified clinical nurse specialists practising in a wide range of acute and community settings across B.C. To access this population, staff from the Registered Nurses Association of British Columbia sent a notice on behalf of the research team to the 273 nurses who identified themselves as clinical nurse specialists on the Registered Nurses Association of British Columbia’s database and who gave permission to contact them for such purposes. We used the database to access this population because the clinical nurse specialist role is the only established advanced nursing practice role in the province and because we believed that many nurses in non-bedside roles might identify themselves as clinical nurse specialists.
Table 1
Phases and Associated Questions and Objectives

<table>
<thead>
<tr>
<th>Phase</th>
<th>Question</th>
<th>Objectives</th>
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| I     | What is advanced nursing practice in B.C.?                               | 1. To clarify the role and understanding of advanced nursing practice and related roles within the larger healthcare system  
                                                    2. To identify the current status of advanced nursing practice and related roles in B.C.  
                                                    3. To identify perceived gaps in healthcare services in B.C. that might be filled by the expansion and/or introduction of new nursing roles |
| II    | What could be advanced nursing practice in B.C.?                          | 4. To explore and describe models of advanced nursing practice in other jurisdictions and determine their potential usefulness and feasibility in B.C.                                                                 |
| III   | What will advanced nursing practice be in B.C.?                           | 5. To explore and describe models of advanced nursing practice in other jurisdictions and determine their potential usefulness and feasibility in B.C.  
                                                    6. To identify barriers to implementing new nursing models in B.C.  
                                                    7. To identify and recommend future policy directions for new nursing models in B.C.                                                                 |

We then conducted 35 telephone interviews and 12 e-mail surveys. All interviews were recorded verbatim and later transcribed. No names or identifying information were included in transcriptions, field notes, or surveys.

To analyse the data, we created an inductively-derived coding framework based on incoming data, the Canadian Nurses Association framework, and data from a previous study of nurse practitioners in B.C.9 Using this framework, we moved between inductive and deductive data collection and coding, conducting a thematic analysis individually and together with the rest of the research team.
In Step 2, we held six two-hour focus groups in Victoria, Vancouver, and Prince George with 55 nurses who likely met the Canadian Nurses Association’s criteria for advanced nursing practice. We identified these nurses by contacting the Registered Nurses Association of British Columbia’s Clinical Nurse Specialist Professional Practice Group and inviting participation of nurses who were likely to meet the Canadian Nurses Association’s criteria for advanced nursing practice. All focus groups but one were audio-taped and transcribed (the one exception was caused by unforeseen technical difficulties), and we took careful notes at each focus group. The resulting data were analysed as in Step 1, which is described above.

In Step 3, we conducted telephone interviews with 29 nurses who work in settings with potential for advanced nursing practice roles to develop (such as primary care demonstration sites, Red Cross hospitals, mental health settings, and outpost stations). We recruited participants by identifying sites based on variation in factors like geography, organizational structure, and population served. The resulting data were analysed as in Step 1, which is described above.

In Step 4, we conducted an email survey of 67 senior human resource officers and nurse leaders in health authorities across B.C. At the time of the sample development, there were 52 health authorities in B.C. We intended to select a sample of approximately 30 of 201 employers for a telephone interview. However, a change in government, restructuring of ministries, and job actions by doctors, nurses, and other healthcare providers resulted in employers being largely unable to participate in telephone interviews. We therefore delayed Step 4 until reorganization was complete. We then distributed 201 e-mail surveys to human resource officers and senior nurse leaders in the newly-created six health authorities. Despite repeated attempts to increase the number of responses, only 67 surveys were returned — a disappointing 33 percent response rate. We coded the open-ended questions and then entered coded data and responses to multiple-choice questions into SPSS-X. Data analyses were limited to descriptive statistics, cross tabulations, and non-parametric tests of significance (such as chi square analysis).

Phase 2 answered the question, *What could be advanced nursing practice in B.C.?* To fulfil this phase’s objective, we selected a case study approach as the most appropriate design.
because this objective covers a range of descriptive, interpretive, and explanatory intents, all of which can be addressed with a case study approach. We conducted a series of five case studies, three in Ontario and two in Washington State. These case studies augment those in the earlier, related study on nurse practitioner practice in B.C.\textsuperscript{vi} to provide a rich sampling of different models of nurses currently working in new and/or advanced roles. Sites were selected to represent as much diversity as possible and variation on the following features: location (urban vs. rural), area of specialization, regulatory framework, funding arrangements, longevity of the role, population served, and the experience and education of the nurse.

In each of the case study sites, we used a combination of purposive and snowball sampling to obtain our sample. Participants included nurses, physicians, other providers, administrators, and patients. Wherever possible, data were augmented by interviewing key informants in regulatory or professional organizations. Documents, such as job descriptions, program descriptions, newsletters, legislation, standards of practice, annual reports, and practice protocols, were also collected.

Data collection included one-to-one interviews, job shadowing, observations and document reviews. Most interviews were audio-taped and transcribed verbatim, and researchers wrote field notes throughout the case study. In addition, analytical case study discussions among research team members were taped. An inductively-derived data collection framework based on the concepts that emerged from the Phase 1 data was modified for Phase 2. Researchers individually and as a team inductively analysed case study data, first within cases and again across cases.

Phase 3 answered the question, \textit{What will advanced nursing practice be in B.C.?} To fulfil this phase’s three objectives, we sought and obtained a purposive sample of individuals knowledgeable and/or influential about advanced nursing practice to participate in a two-day think-tank. We invited 95 people from B.C., elsewhere in Canada, and the U.S. to participate. The 80 people who participated were 17 nurses, six physicians, 19 employers, three researchers (other than research team members), four educators, three representatives of government, 11 representatives of professional organizations, 10 members of the referent group, and seven members of the research team.
The think-tank agenda alternated between presentation of information on data results from the first two phases of the study and small-group work on a series of questions related to the information. Most sessions were taped, discussions were recorded as completely as possible on flip charts, and research team members took extensive notes, which became part of the data. Data analysis began at the end of the first day when research team members did a thematic analysis of all data collected and identified a short list of key issues and challenges to be addressed in small-group work the following day. After the think-tank ended, the research team held a debriefing meeting. Think-tank data were analysed inductively using a thematic approach, first by a researcher, who prepared a draft report of findings, and again by the team in the debriefing session. Data from that meeting was included in the final data analysis prepared by the researchers.

Results
The results of each phase of this study are presented below.

Phase 1 clarified the role and understanding of advanced nursing practice and related roles within the larger healthcare system; identified the current status of advanced nursing practice and related roles in B.C.; and identified perceived gaps in healthcare services in B.C. that might be filled by expansion and/or introduction of new nursing roles.

Findings from steps 1 to 3 are reported concurrently because preliminary analysis revealed an overlap in the findings from each phase. Nurse participants described both formal and informal education and experience as sources of their current level of knowledge and skills. There were notable differences in participants’ descriptions; these differences were related to the participants’ level of nursing education. The majority of participants stated that advanced nursing practice included working independently and having a specialized body of knowledge. In step 1, participants with graduate-level education were more likely to describe advanced nursing practice from a population health or systems-level perspective than were those with diploma or baccalaureate education levels. The latter were more concerned with management of an individual client’s care. Step 2 participants described advanced nursing practice as including advanced knowledge, theory, skill in practice, education, and research that was developed over time, and rejected notions of advanced practice nursing defined in
terms of performance of medical tasks. Nurses in step 3 described advanced nursing practice in terms of having a wide scope of practice and performance of certain tasks or skills. Most participants identified themselves as working in advanced nursing practice roles, irrespective of the congruence of their practice with the Canadian Nurses Association framework. Only eight percent (11 of 131 participants) indicated otherwise. There was variation in the degree to which participants thought they were working to their full potential, although many expressed a belief that they were capable of doing much more than they currently did. Participants saw opportunities for expansion of advanced nursing practice, particularly in health promotion, illness prevention, chronic disease management, and primary care.

Participants varied in their responses on their authority to practise and cited sources ranging from formally or informally delegated authority as well as legislated registered nurse scope of practice and other guidelines. Participants identified a number of supports to their practice, including an understanding of their role within the organization; supportive working relationships with nursing, medical, and other colleagues; infrastructure supports; continuing education opportunities; and policies, guidelines, and standards. Participants identified challenges to their practice as a lack of understanding by others of their role, financial issues, continuing education, physician resistance, and the need to establish personal credibility. They also cited difficulties with protocols, systems issues, lack of direct line authority, lack of regulatory legislation, and working conditions as challenges. Benefits of advanced nursing practice were identified as cost-effectiveness, efficiency, and quality of care, as well as positive impacts on patients and on nursing practice itself. All participants recognized the need for advanced education that provided knowledge and skills to perform in an advanced nursing practice role. They emphasized the need for practical experience within educational programs and the need for accessible continuing education.

Step 4 results were hampered by a low response rate (33 percent) and by over-representation of respondents from the Northern and Interior health authorities, which represent rural areas. Service gaps identified by employers included primary care, health promotion and disease prevention, services for seniors, and mental health services. In addition, participants identified that there were only a small number of qualified staff. Participants identified priority service gaps in geriatrics, mental health, primary care, and palliative care that could be addressed by clinical nurse specialists. They identified priority service gaps in primary
care, palliative care, and women’s health that could be addressed by nurse practitioners. Overall, the majority of respondents rated all Canadian Nurses Association competencies for nurses in advanced practice roles as being at least somewhat important. As well, the hallmark of advanced nursing practice, specialized knowledge and expertise, was rated very important by 96 percent of respondents, while medical functions were rated substantially lower in importance (from 37 to 49 percent).

Phase 2 explored and described models of advanced nursing practice in other jurisdictions and determined their potential usefulness and feasibility in B.C. We conducted a series of case studies in which we examined six models of advanced nursing practice in five sites in Canada and the U.S. Factors that influenced the development of roles included gaps in healthcare services for particular populations, health needs, geographical areas, physician shortages, and a welcoming political climate. As might be expected, physicians and organized medicine were perceived as both challenges and key supports for implementation. Physicians who were experienced with nurses working in advanced nursing practice roles were highly supportive of the role and of the nurses.

Roles varied in autonomy and scope of practice. They ranged from the more limited scope of practice of the extended-class registered nurses who are nurse practitioners in the Ontario urban community health centre and who worked with lists and protocols, to the advanced registered nurse practitioners in the rural primary care clinic who had completely autonomous practice. Authority to practise outside the traditional nursing scope of practice varied. Advanced registered nurse practitioners and certified registered nurse anaesthetists had autonomous practice, while acute-care nurse practitioners worked under medical delegation. With the exception of extended-class registered nurses who are nurse practitioners, all nurses in this study had a minimum of graduate preparation in nursing. Extended-class registered nurses who are nurse practitioners were prepared at the baccalaureate and certificate level, although plans were underway to increase educational preparation required to enter practice. In the American settings, re-registration involved demonstration of continuing education credits in the area of specialty.
Reporting relationships varied among the six models and largely related to the practice setting (acute vs. community care). In two acute-care settings, in roles in which medical functions were at the forefront, the nurses had some degree of reporting relationships with physicians; however, this varied from direct reporting (certified registered nurse anaesthetists) to a more complex multiple reporting structure (clinical nurse specialist — neonatal practitioners) that included a physician, nurse, and program director. In the community settings, nurses reported to a non-physician administrator. Acute-care nurse practitioners in the tertiary oncology site, where nursing was in the foreground, reported to a director of nursing. In Canadian acute-care settings, advanced nursing practice was viewed and enacted in ways that were consistent with the Canadian Nurses Association’s framework, incorporating research, consultation, advanced nursing knowledge and skills, in-depth clinical expertise, and leadership in daily practice. In community settings, understandings of advanced nursing practice were framed by the regulatory parameters of practice — nurses understood they had the legal authority, skill, and education to practise certain medical skills autonomously.

Overall, it was clear that the benefits of advanced nursing practice were evident to all those who worked with nurses in advanced nursing practice roles. Participants and key informants (including patients) to whom we spoke believed that advanced nursing practice roles benefited patients, families, other professionals, and the organizations in which they worked. Respondents identified a number of health service gaps that could be filled by nurses in advanced nursing practice roles, as well as a number of ways in which advanced nursing practice itself could be expanded. Supports for advanced nursing practice included those that promoted role implementation (philosophical and administrative commitment and tangible support) and those that supported nurses in practice (collegial relations, continuing education, and infrastructure). Challenges for advanced nursing practice included those that were barriers to role implementation and role enactment. Challenges to role implementation were mainly organization-specific and related primarily to structures, policies and culture within organizations and specific work units. Challenges to role enactment were mainly case-site specific and included lack of leadership and vision for the role; lack of support for new nurses entering the role; use of medical directives; managing multiple demands; allowing for protected time for research and other professional activities; lack of a physician colleague for
consultation; accessing continuing education to maintain registration; and limitations in the job description to fully enact an advanced nursing practice role.

Financial considerations included position funding and compensation. All positions were funded from base funding, although sources of funding varied from a government-funded global budget to fee-for-service. All nurses were in salaried positions, and compensation was generally in line with education and responsibility of nurses in advanced nursing practice roles. Their wages were considerably higher than those of staff registered nurses.

Phase 3 examined primary issues in the development of advanced nursing practice roles: (a) the need for clearer roles; (b) autonomous practice is essential; and (c) professional collaboration is inherent in the role. It was agreed there is a need for ongoing research and evaluation of the effectiveness of advanced nursing practice roles and that a strong public relations campaign is needed to communicate and market the role to public, government, employers, and other healthcare providers. Government support and commitment is essential for the development, implementation, and sustainability of the role. Government was seen as having primary responsibility for (a) legislation; (b) provision of adequate funding for public relations; (c) funding of educational programs for entry to advanced nursing practice and for continuing education; and (d) funding and deployment of advanced practice nurses. Other government responsibilities identified by participants included collaboration with others in developing public relations, education, employment, infrastructure, and addressing quality of worklife issues.

Participants acknowledged in a variety of ways and at different times throughout the think-tank that implementing advanced nursing practice roles will not be easy because all challenges and issues are interdependent. This makes it impossible to find easy or incremental solutions. Participants expressed the view that we cannot search for easy solutions or wait until issues such as education and legislation are addressed. The greatest challenge of implementing advanced practice nursing will be addressing change and implementing strategies on many fronts at the same time.
Resources

These full reports are available from the authors:


- Both Dr. Rita Schreiber and Dr. Marjorie MacDonald can be reached at the University of Victoria School of Nursing, 250-721-7954.

This publication is in press:


Additional research needs to be done. As B.C. moves towards fully implementing advanced nursing practice, it is vital to evaluate the implementation of such practice. Given pending nurse practitioner legislation and regulation in B.C., an important research question relates to how the nurse practitioner role is implemented and integrated into the B.C. health system. Specifically, can evidence-based planning result in successful implementation, and what does the role look like in practice? Important objectives of such a study would include:

- to determine the use of specific implementation strategies developed by the Ministry of Health Planning and the Registered Nurses Association of British Columbia to facilitate nurse practitioner role implementation;

- to identify the most important influences on nurse practitioner role implementation in a variety of settings;

- to determine the extent and nature of nurse practitioner role implementation;

- to explore the experiences of nurse practitioners as they go through the registration process;
to explore the experiences of nurse practitioners as they implement their roles;

to study in-depth the process by which the nurse practitioner role is implemented, and the influences on that process, in selected settings in B.C.; and

to lay the groundwork for a subsequent study that would explore the impact and outcomes of nurse practitioners’ practice in this province.

Additional research should be done that explores the feasibility of adopting nurse anaesthesia as an advanced nursing practice role in Canada.

Resources
This section of the report highlights those items most useful for decision makers and researchers wanting to do more reading. The report’s footnotes appear after the bibliography.


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iv Ibid.


vi Ibid.